C52

NEWARK PUBLIC LIBRARY

JAN 9 1986

U. S. GOVT. PUBS.
DEPOSITORY 326

"claims liability management in health maintenance organizations"

HMO

Department of
Health and Human Services
Public Health Service
Office of
Health Maintenance Organizations
Rockville, Maryland

READEX FICHE

HE 20.2:

CLAIMS LIABILITY MANAGEMENT IN HEALTH MAINTENANCE ORGANIZATIONS

Prepared by Birch & Davis Associates, Inc.
Under Contract No. 282-79-0093-SW

Department of Health and Human Services,
Office of Health Maintenance Organizations

April 1981

11

FOREWORD

One of the most common and complex management problems experienced by HMOs is the determination of its liability for claims from fee-for-service providers.

HMOs incur fiscal liability at the time services are provided; however, the exact costs of such services are not known until bills for such services are actually received by the HMOs. Consequently, it is necessary for HMOs to estimate costs resulting from these fee-for-services which have not yet been billed.

This monograph is designed to help HMO managers understand how to deal with the problems associated with claims liability control. It contains several suggestions on how to manage claims liability and associated management procedures. It also includes options for forms now in use in operating HMOs.

This technical assistance document should be a valuable resource to operating HMOs in the design and implementation of effective claims liability management systems.

Frank Seubold

Frank H. Seubold, Ph.D.

U

11

LIST OF EXHIBITS

Exhibit Number		Following Page
I-1	TYPICAL FEE-FOR-SERVICE LIABILITIES BY HMO MODEL TYPE	I-1
I-2	DIFFERENCES WHEN OUTSTANDING CLAIMS ARE NOT ACCOUNTED FOR	I-5
II-1	CLAIMS LIABILITY MANAGEMENT CYCLE	II-1
II-2	CLAIMS LIABILITY MANAGEMENT PROCESS PHASES	II-1
II-3	CLAIMS AND PRIOR NOTIFICATION FORMS FLOW	II-4
II-4	CLAIMS PROCESSING CYCLE	II-4
II-5	CLAIMS LIABILITY DETERMINATION PROCESS	II-11
II-6	DETERMINING CLAIMS LIABILITIES WITHOUT HISTORICAL DATA—EXAMPLE	II-12
II-7	SAMPLE CLAIMS LAG REPORT	II-14
II-8	SAMPLE CLAIMS LAG MEASUREMENTS	II-14
II-9	ILLUSTRATIVE DEVELOPMENT OF INCURRED BUT NOT REPORTED CLAIMS LIABILITY	II-17

11

TABLE OF CONTENTS

Chapter		Page
	INTRODUCTION	1
I.	PROBLEMS HMOs HAVE EXPERIENCED IN CLAIMS LIABILITY MANAGEMENT	I-1
	1. Inadequate Or Unclear Policies And Procedures For Claims Preparation And Submission, Prior Notifications, And External Provider Claims	I-1
	2. Claims Tracking, Processing, And Accounting Procedures Are Inadequate	I-3
	3. Determining Incurred But Not Reported Claims Liabilities Has Been A Major Problem For All HMO Model Types	I-4
II.	A CLAIMS LIABILITY MANAGEMENT SYSTEM	II-1
	PHASE 1: Establish Procedures For Collecting And Controlling Data	
	1. Claims Must Be Prepared In Accordance With Clear Policies	II-1
	2. Techniques Must Be Used To Foster Effective Claims Tracking	II-4
	PHASE 2: Monitoring, Reporting, And Analyzing Claims Activity	
	1. In The IPA Model HMOs, Primary Care Physician Claims Must Be Monitored	II-5
	2. Both Written And Telephone Procedures Can Be Used To Monitor Referral Specialist And Inpatient Facility Claims Experience	II-5
	3. Utilization Patterns Should Be Analyzed To Foster Control And Facilitate Claims Liability Forecasting	II-9

TABLE OF CONTENTS (Continued)

	Page
PHASE 3: Determining Claims Liabilities	
1. Determining Claims Liabilities Without Significant Historical Claims Data	II-11
2. Determining Claims Liabilities Based On Historical Claims Data	II-15
PHASE 4: Recording The Liability	II-18

* * * * *

Appendices

A. SAMPLE CLAIMS POLICIES AND PROCEDURES

Policy Or Procedure	Page Number
Claims Processing Procedure	A-1 - A-4
Primary Care Physician Claim Form Submission Policy	A-5 - A-11
Claims Form Submission Policy From Primary Care Physician Provider Manual	A-12 - A-20
Explanation Of Primary Care Physician Remittance Advice	A-21 - A-28
Participating Specialist Referral Procedure	A-29
Non-Participating Specialist Referral Procedure	A-30 - A-31
Referral Procedure	A-32
The Primary Care Referral System	A-33 - A-34
Inpatient Admission Log	A-35

TABLE OF CONTENTS (Continued)

	Page
B. SAMPLE CLAIMS AND SERVICE NOTIFICATION FORMS	
Claim Form	
Generalized Primary Care Claim Forms	
General Services Encounter Form With Pre-Printed Codes	B-1 - B-2
Physician Service Statement	B-3
Primary Care Claim Forms By Provider Type	
General Medicine	B-4 - B-5
Family Practice	B-6
Internal Medicine	B-7
Internal Medicine	B-8
Obstetrics And Gynecology	B-9
Obstetrics And Gynecology	B-10
Pediatrics	B-11
Laboratory	B-12
Referral Notification And Claim Forms	
Referral Notification	B-13
Referral Notification	B-14
Inpatient Admission Notification	
Authorization For Hospitalization	B-15
Admission Authorization	B-16
Hospital Admission Certification	B-17
Request For Extension Of Certification	B-18
Combined Referral And Inpatient Notification Form	
Referral Form	B-19

11

INTRODUCTION

One of the most common and confusing financial management problems experienced by HMOs is fee-for-service claims liability. The precise scope of fee-for-service liability varies with the HMO's size, its model type, and most important, its contractual and fee-for-service relationships with providers of health services. All HMOs, however, are faced with problems in this area to one degree or another.

The HMO's fee-for-service liability may include the following types of services:

- Primary care physician and ancillary services
- Referrals for physician specialty and ancillary services
- Inpatient institution services including hospital, long term care facility, and mental health services
- Hospital emergency room services
- Out-of-area hospital and physician services
- Pharmacy services
- Other services including ambulance and home health care

Generally, IPA model HMOs or the IPA itself are at risk of financial liability for all of the services listed above. Staff model HMOs, with salaried primary care physicians, generally have the same scope of fee-for-service liability as the IPA, with the important exception of primary care. This is generally the case for medical group model HMOs as well. It is important to note, however, that an HMO's contractual and fee-for-service relationships with providers, including medical groups and independent practice associations, are the principal factors determining the plan's liability in this regard.

Although HMOs incur a liability at the time services are provided, they do not become aware of the exact costs of such services until sometime later. Consequently, many HMOs identify the approximate, if not actual, cost of services provided on a fee-for-service basis by using information procedures that collect data about the services when they are incurred, rather than when the actual claim is received. This information, coupled with estimates of liabilities for which no advance information is available (e.g., out-of-area emergencies) allows the HMO to accurately forecast its claims liability.

Accurate forecasting of claims liability allows the plan to:

- Determine cash flow needs
- Develop reliable accrual basis financial reports
- Monitor the use of provider services

- Control costs

- Establish a realistic, financially viable premium rate and revise the same as needed

For purposes of proper financial management, an HMO's claims liability falls into two categories:

- Reported But Unpaid Claims—Liability for claims received but not yet paid can be accurately determined, provided the plan has adequate procedures for processing these claims. In some cases, the sheer volume of claims received, combined with a lack of proper accounting procedures, contributes to the plan's failure to accurately determine this liability.

- Incurred But Not Reported Claims—Determining the liability for claims not yet received requires aggressive information collection. HMOs can determine the status of incurred liabilities prior to claims receipt by monitoring services as they are provided and, where sufficient historical data exists, by using appropriate estimation techniques.

This monograph is designed to help HMO managers understand the problems associated with claims liability control and to provide them with proven techniques for handling these problems. The claims liability management system presented in Chapter II is essentially an information collection system. It enables HMO administrative personnel to interact with providers, including physicians and hospitals, through forms and telephone communication. This communication provides HMO managers with all information necessary to accurately determine its claims liability.

The remainder of the monograph is organized into the following sections:

- Chapter I—Problems HMOs Have Experienced In Managing Their Claims Liability

- Chapter II—A Claims Liability Management System

- Appendices—Claims Liability Management Procedures and Forms

CHAPTER I

PROBLEMS HMOs HAVE EXPERIENCED IN CLAIMS LIABILITY MANAGEMENT

I. PROBLEMS HMOs HAVE EXPERIENCED IN CLAIMS LIABILITY MANAGEMENT

Each HMO's claims liability is a function of its contractual and fee-for-service relationships with health services providers. Generally, staff and group model HMOs have a more limited scope of fee-for-service claims liability than do IPA/HMOs. The monograph addresses all HMOs, specifying model type only in the few cases where it is a factor.

Exhibit I-1, following this page, presents a chart of typical fee-for-service liabilities by HMO model type. It is important to note that there are exceptions to these examples. Again, each plan's claims liabilities will be a function of its own arrangements for health services.

Developing HMOs have experienced particularly acute problems in managing their claims liability, because they often do not anticipate the size of the problem, and lack a well established and stable pattern of health services utilization. All HMOs, whatever their stage of development, face potential disaster if problems in this area are not brought and kept under control. Problems have resulted from three principal factors:

- Inadequate or unclear policies and procedures for claims preparation and submission, and prior notifications*
- Poor tracking, processing, and accounting practices in the HMO
- Failure to identify incurred but unreported claims liabilities

Each of these factors is discussed below. Chapter II presents a system designed to correct these problems.

1. INADEQUATE OR UNCLEAR POLICIES AND PROCEDURES FOR CLAIMS PREPARATION AND SUBMISSION, PRIOR NOTIFICATIONS, AND EXTERNAL PROVIDER CLAIMS

Some problems occur very early in the service/claims cycle—before service is provided or when providers record and submit claims—as a result of inadequate or misunderstood HMO policies and procedures. This often results from the HMO's failure to inform providers of the plan's policies and procedures, including each party's respective responsibilities.

---

* Prior notifications refer to written or telephone notice to plan administration of outpatient specialty services or inpatient admissions ordered by a member's primary care physician. Although Federal regulations and policies do not require prior notification, most HMOs do. Specifically, as a matter of internal policy, most HMOs require primary care physicians to provide prior notification of all specialty services and inpatient admissions—with the exception of emergency situations. This procedure is highly recommended.

EXHIBIT I-1

TYPICAL FEE-FOR-SERVICE LIABILITIES
BY HMO MODEL TYPE

FEE-FOR-SERVICE LIABILITY AREA	HMO MODEL TYPE		
	STAFF	GROUP	IPA
Primary Care Physicians			X
Referral/Specialty Physicians	X	(sometimes)	X
Inpatient Services	X	X	X
Emergency Room	X	X	X
Ancillary Services	(sometimes)		X
Prescriptions	(sometimes)	(sometimes)	(sometimes)
Out-Of-Area	X	X	X

(1) Poor Procedures For Preparing And Submitting Claims

Unclear and non-uniform procedures for preparing and submitting claims can result in untimely and error-prone claims and make it difficult for the HMO to estimate the number of outstanding claims. Problems can result from:

- Poorly Designed Claim Forms—Forms that are cumbersome to use (e.g., that require extensive information or do not contain check-off responses wherever possible; that require carbon paper) are likely to contain errors and inspire procrastination by providers.

- Loose Or Non-Existent Deadlines For Claims Submission—Some HMOs do not specify the maximum time period from the date of service within which claims must be submitted. This makes it quite difficult for plans to determine the volume and value of outstanding claims.

(2) Inadequate Procedures For Prior Notifications And External Provider Claims

Most HMOs bear liability for services (covered in the subscriber's contract) provided or approved by the HMO member's primary care physician. The primary care physician usually has responsibility for ordering all specialty referral care, inpatient admissions and services, and ancillary services. In effect, the primary care physician in most HMOs determines the services to be provided to his/her patients.

Many HMOs require that primary care physicians provide plan management with prior notification and documentation of referral specialty care and inpatient admissions. This procedure serves as a purchase order system, alerting HMO management to an impending liability and providing documentation of the resulting claim's appropriateness. This procedure is discussed in detail later.

Problems occur when an HMO fails to require prior notification of these services being ordered. In these cases, the HMO has no advance notice as to the nature or extent of its liability, nor does it have any document against which the claim—when it finally is received—can be verified to assure that it is a bona fide claim within the scope of the plan's membership eligibility and coverage requirements.

Moreover, if the HMO, specifically the Medical Director or designee, does not have the opportunity to review the proposed services before they occur, it will lose effectiveness in influencing medical practice patterns, such as suggesting alternative, perhaps less costly approaches.

(3) Inadequate Member Education

The HMO must assume responsibility for educating its members as to covered services and procedures to be followed in receiving care. An

appropriate understanding on the part of HMO members regarding these issues can serve to reinforce the HMO's claims processing and payment policies and procedures.

(4) Unclear Contracts Between The HMO And Its Providers

Problems often arise when contracts or reimbursement agreements between the HMO and providers of health services, including primary care physicians, hospitals, and specialists, do not specify: procedures for claims submission, including deadlines; requirements for prior notification or certification; as well as rates of reimbursement. Questions and disputes as to each party's liability may arise due to incomplete or poorly constructed contractual agreements.

2. CLAIMS TRACKING, PROCESSING, AND ACCOUNTING PROCEDURES ARE INADEQUATE

Both new and more established HMOs have experienced a variety of problems in managing claims through their entire cycle. Problems associated with each step of the claims management process are discussed below.

(1) Failure To Track Prior Notifications And Verify Claims

As noted earlier, virtually all HMOs limit coverage to services provided or ordered by a member's designated primary care physician. Many HMOs do not have a tracking system to determine whether services for which it receives a claim have been so ordered. Unless HMOs verify: the primary care physician's prior notification (i.e., order); scope of services ordered; member's eligibility and scope of coverage at the time of service; and, the appropriateness of the charge(s), the HMO is likely to assume excess liabilities from time to time, if not often.

In the case of primary care physician claims, usually associated with IPA model HMOs and generally not requiring prior notification, a comparable, yet somewhat different problem arises. Most IPAs receive a claim from the primary care physician for services performed in the physician's office, while many ancillary services such as laboratory and X-ray are billed directly by the providing party. Some, if not most, HMOs have no mechanism for linking claims from the local laboratory or radiologist to services ordered during a visit to the member's primary care physician. Consequently, the HMO is unable to effectively determine the appropriateness of these claims.

Some HMOs do not enforce their prior notification policies when discrepancies are discovered and actually pay claims in the absence of appropriate documentation. As a result, they may pay for services that duplicate those provided or ordered elsewhere by the primary care physician, particularly ancillary services such as laboratory and X-ray. Although these claims may be limited in volume, their unit costs tend to be high. Accordingly, inadequate procedures for verifying and tracking these transactions can result in enormous unforeseen or illegitimate incurred liabilities. Additionally, in the absence of uniform procedures for tracking these transactions, plans have experienced great difficulty in monitoring the referral and admitting activities of primary care physicians.

An HMO's liabilities are broad enough without having to assume additional liabilities beyond the scope of its subscriber and provider contracts or agreements. Plans failing to review and verify their referral, inpatient, and in the case of IPA models, primary care claims, establish payment patterns destined to result in significant financial losses.

(2) Inconsistent Or Incomplete Logging Of Received Claims

Some HMOs have suffered from the "shoe-box syndrome," whereby received claims are shelved without being recorded and processed on a timely basis. The result of this administrative expediency is understatement of the HMO's actual claims liability, until the "shoe box" is discovered. The effect has been disastrous. In some instances, HMOs, believing themselves in sound financial condition, have suddenly identified an overwhelming liability, heretofore unrecognized.

(3) Failure To Use The Accrual Basis Of Accounting

To obtain a more accurate financial status report, HMOs must account for both reported but unpaid and incurred but not reported claims liabilities. Because the former claims are in the HMO's possession, determining the actual liability deriving therefrom is fairly easy. In contrast, incurred but not reported claims liabilities (discussed in the next section) are more difficult to determine. A plan's failure to employ accrual basis accounting will create significant problems, even when claims have been reported timely and processed diligently.

3. DETERMINING INCURRED BUT NOT REPORTED CLAIMS LIABILITIES HAS BEEN A MAJOR PROBLEM FOR ALL HMO MODEL TYPES

Incurred but not reported (IBNR) claims liabilities are associated with services provided to HMO members for which the HMO has not yet received a claim. There will always be a delay between the time the HMO has incurred a liability (i.e., service has been provided) and the point at which the HMO recognizes the liability in its accounting records. Consequently, as of month's end, the HMO must determine this incurred but not reported liability in order to reflect the true financial position of the plan.

HMOs have two options for determining their incurred but not reported claims liabilities:

- Determine the approximate or actual cost of each such service prior to receiving the actual claims
- Estimate the cost of these services based on historical data

Each of these approaches to determining an HMO's incurred but not reported claims liabilities is discussed in detail in Chapter II. At this time, the problems HMOs have experienced in this area is the focus of discussion. HMOs have experienced five principal problems related to incurred but not reported claims:

- Failure to use prior notification information
- Failure to obtain or analyze claims lag reports

- Failure to use any liability determination technique
- Use of an inappropriate estimation technique
- Failure to record claims liabilities in an IPA's financial records

(1) Failure To Use Prior Notification Information

Unfortunately, even some HMOs using one or another prior notification procedure for specialty referral and inpatient services fail to use this information to anticipate the cost of services provided and, thus, the HMO's claims liability. In some cases, HMOs accumulate data about anticipated and actual utilization of specialist and inpatient services, but use it only for statistical purposes, and not to determine claims liability. Consequently, the prinicipal purpose of the notification procedure—identifying impending claims liabilities—is undermined.

(2) Failure To Obtain Or Analyze Claims Lag Reports

Those HMOs with sufficient historical claims data can use various estimation techniques to determine current incurred but not reported claims liabilities. These techniques should be used in conjunction with prior notification procedures, a point discussed in detail in Chapter II. To estimate a plan's claims liability accurately, plan management must routinely collect and analyze data concerning the length of time between provision of service, receipt of claims, and processing of claims. Unfortunately the management information systems of some HMOs are inadequate in providing data necessary for this analysis.

Some HMOs have experienced problems that derive from their inability to distinguish between the typical lags associated with various provider types. For example, the lag factor for physician claims is different from that for hospital claims. Consequently, plans need separate data on these provider types to estimate their claims liabilities for a particular accounting period.

In other instances, HMOs have routinely produced appropriate claims lag reports, but these data have not been analyzed and used for claims liability management. This problem contrasts with that of newer, developing HMOs that lack sufficient claims lag data on which estimates of liability may be based. This problem is addressed in the next chapter.

(3) Failure To Use Any Technique For Determining Incurred But Not Reported And Reported But Unpaid Claims Liabilities

Some HMOs have failed to account for incurred but not reported claims as a liability in the plan's financial records. By failing to identify this liability, the HMO has misrepresented its actual financial position. Exhibit I-2, following this page, shows the difference in a hypothetical developing HMO's financial position when incurred but not reported and reported but unpaid claims liabilities are and are not recorded, i.e., estimates accrued. Section A of the Exhibit does not include estimates of these outstanding liabilities. Section B shows the same time period, but includes estimates for both incurred but not reported and reported but unpaid claims. The difference in reported net earnings resulting from these two accounting practices is over

EXHIBIT I-2

DIFFERENCES WHEN OUTSTANDING CLAIMS ARE AND ARE NOT ACCOUNTED FOR

	ACCOUNTING MONTHS			
	1	2	3	4
A. NO ESTIMATE OF OUTSTANDING CLAIMS				
Revenue	$ 14,400	$ 20,200	$ 30,400	$ 65,200
Expense:				
Direct Expense	50,048	52,000	57,566	74,165
Claims Expense (1)	2,500	3,250	3,540	3,800
Total	$ 52,548	$ 55,250	$ 61,106	$ 77,965
Net Gain (Loss)	($ 38,048)	($ 35,050)	($ 30,706)	($ 12,765)
Cumulative Gain (Loss)	($ 38,048)	($ 73,098)	($103,804)	($116,569)
B. ESTIMATE OF OUTSTANDING CLAIMS INCLUDED				
Revenue	$ 14,500	$ 20,200	$ 30,400	$ 65,200
Expense:				
Direct Expense	50,048	52,000	57,566	74,165
Claims Expense (2)	7,700	13,273	21,634	49,065
Total	$ 57,748	$ 65,273	$ 79,200	$123,230
Net Gain (Loss)	($ 43,248)	($ 45,073)	($ 48,800)	($ 58,030)
Cumulative Gain (Loss)	($ 43,248)	($ 88,321)	($137,121)	($195,151)

(1) In this example only claims paid during the month are reflected in this line.

(2) In this example, for the same HMO, estimates for incurred but not reported, reported but unpaid, and actual paid claims are included in this line.

$78,500—from a net loss of $116,569 to a net loss of $195,151, when estimates of the HMO's outstanding claims liabilities are accrued. It is precisely this problem of accounting for the plan's claims expense without estimating incurred but not reported and reported but unpaid claims that has resulted in the demise of some HMOs.

(4) Use Of An Inappropriate Estimation* Technique

Each HMO must use estimation techniques appropriate to its individual circumstances. Problems have arisen when claims liability data from one HMO have been used by another for estimation purposes. Since the lag pattern will vary significantly across plans based on variables such as geographic area, contractual requirements, and volume of activity, generalizations on lag patterns from one HMO to another are risky. Moreover, the lag pattern within a plan may change over time as the HMO becomes more developed and relationships with providers stabilize.

(5) Recording Claims Liabilities In the Financial Records Of A Corporate Entity Other Than The HMO

In some cases, particularly IPA model HMOs, the contractual relationship(s) between the HMO and another corporate entity, (e.g., an Independent Practice Association) limits the HMO's liability to the amount of a monthly capitation payment from the HMO to the other corporation. In this situation, the estimate of claims liabilities should be recorded in the financial records of the other corporation (e.g., the IPA).

In many IPA model HMOs, staff of the HMO are responsible for maintaining the IPA's financial records in addition to those of the HMO. In those cases where the HMO's claims liability is limited to the capitation (per member per month) payments from the plan to the IPA, the IPA's financial records must include a record of the corporation's estimated liability for both incurred but not reported and reported but unpaid claims. In the absence of this procedure, a significant misstatement of the IPA's financial position will result.

* * * * *

Problems in the area of claims liability management are fairly straightforward. Like many management problems, they require that decisions be made in the absence of perfect information. There are, however, proven techniques to assist HMO managers in the task of managing their claims liability. The following chapter provides recommended guidelines on implementing a comprehensive claims liability management system.

---

* The terms "estimate" and "estimation," as used in this section, refer to amounts deterimined either (1) by collecting data about services prior to receiving the actual claim or (2) by developing estimates based on past experience.

CHAPTER II

A CLAIMS LIABILITY MANAGEMENT SYSTEM

II. A CLAIMS LIABILITY MANAGEMENT SYSTEM

The preceding chapter presented various problems HMOs have experienced in managing their fee-for-service claims liabilities. Virtually all of these problems derive from management's failure to perform specific tasks, rather than conceptual complexity of processing and managing HMO claims liabilities. Therefore, solutions are not characterized by complexity, but rather, by simple logic and attention to detail. Acknowledged experts in the HMO field have pointed out that the solutions to claims liability problems can be summed up in two words: "Do it." The emphasis should be placed on "Do," because "it" is neither complex nor elusive.

Managing an HMO's claims liabilities is a cyclical process, as depicted in Exhibit II-1, following this page. This chapter discusses a general system by which HMOs can effectively manage their fee-for-service claims liabilities. Additionally, it discusses specific techniques HMOs can use to maximize the effectiveness of their claims liability management systems. Exhibit II-2, following Exhibit II-1, shows four phases of the claims liability management process:

- Phase 1—Establish procedures for collecting and controlling data
- Phase 2—Monitoring, reporting, and analyzing claims activity
- Phase 3—Determining claims liability
- Phase 4—Recording the liability

The following discussion addresses each phase in greater detail and includes references to material in the appendices. These materials were collected from Federally Qualified HMOs, are used currently to manage claims liabilities, and serve as examples of policies, procedures, forms, and reports discussed in this chapter. The appendices are organized as follows:

- Appendix A—Sample Claims and Prior Notification Policies and Procedures

- Appendix B—Sample Forms

PHASE 1: ESTABLISH PROCEDURES FOR COLLECTING AND CONTROLLING DATA

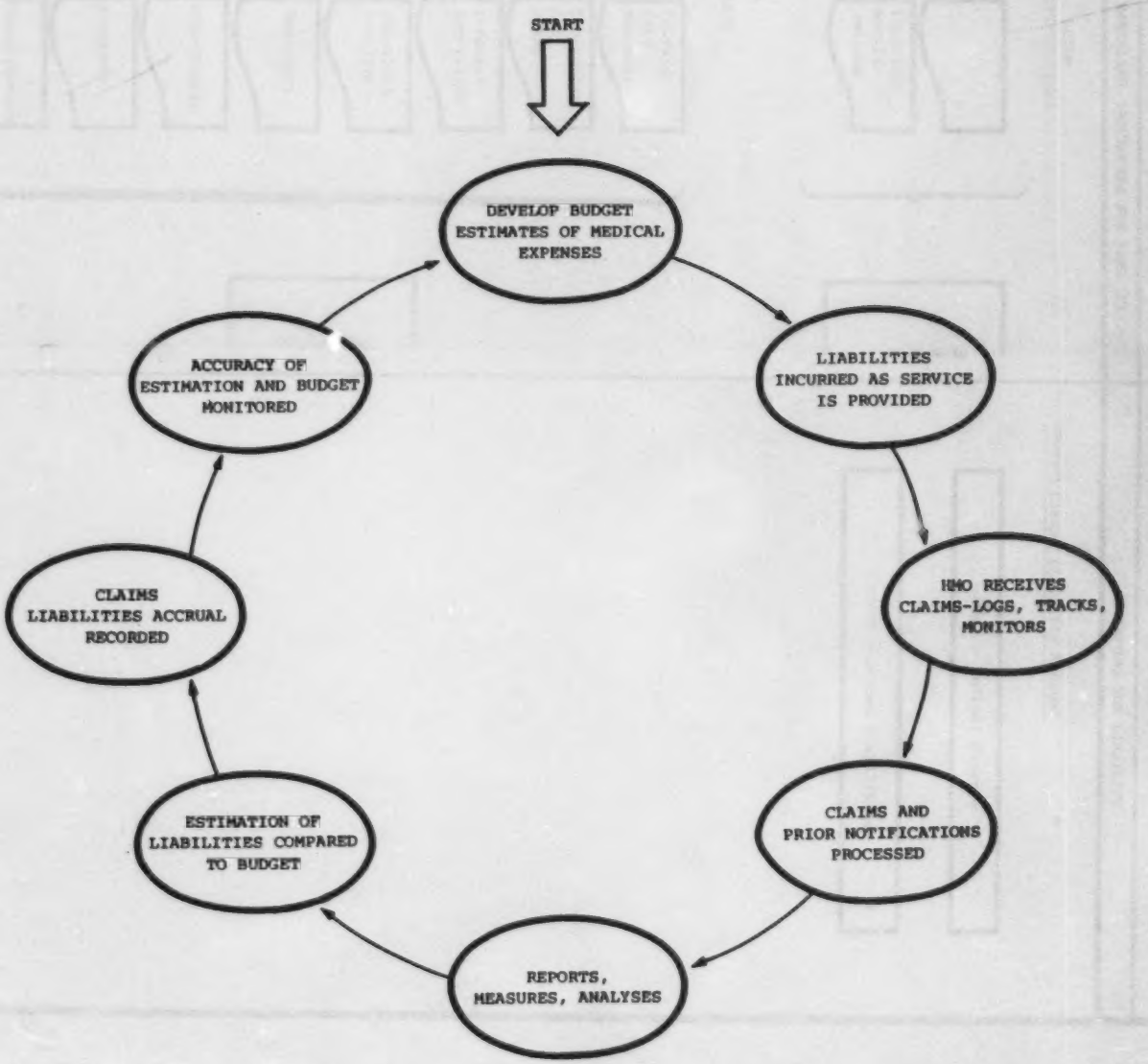
Claims liability management requires that HMOs collect and manage information flowing from many sources in various forms. Therefore, the first two features of the claims liability management system are (1) procedures and policies governing claims generation and (2) techniques for tracking claims. Each feature is discussed below.

1. CLAIMS MUST BE PREPARED IN ACCORDANCE WITH CLEAR POLICIES

To assure the timely receipt of claims and prior notifications for referral and inpatient services, HMOs must develop and implement procedures and instructions for forms completion and submission. The purpose of these procedures and

EXHIBIT II-1

CLAIMS LIABILITY MANAGEMENT CYCLE



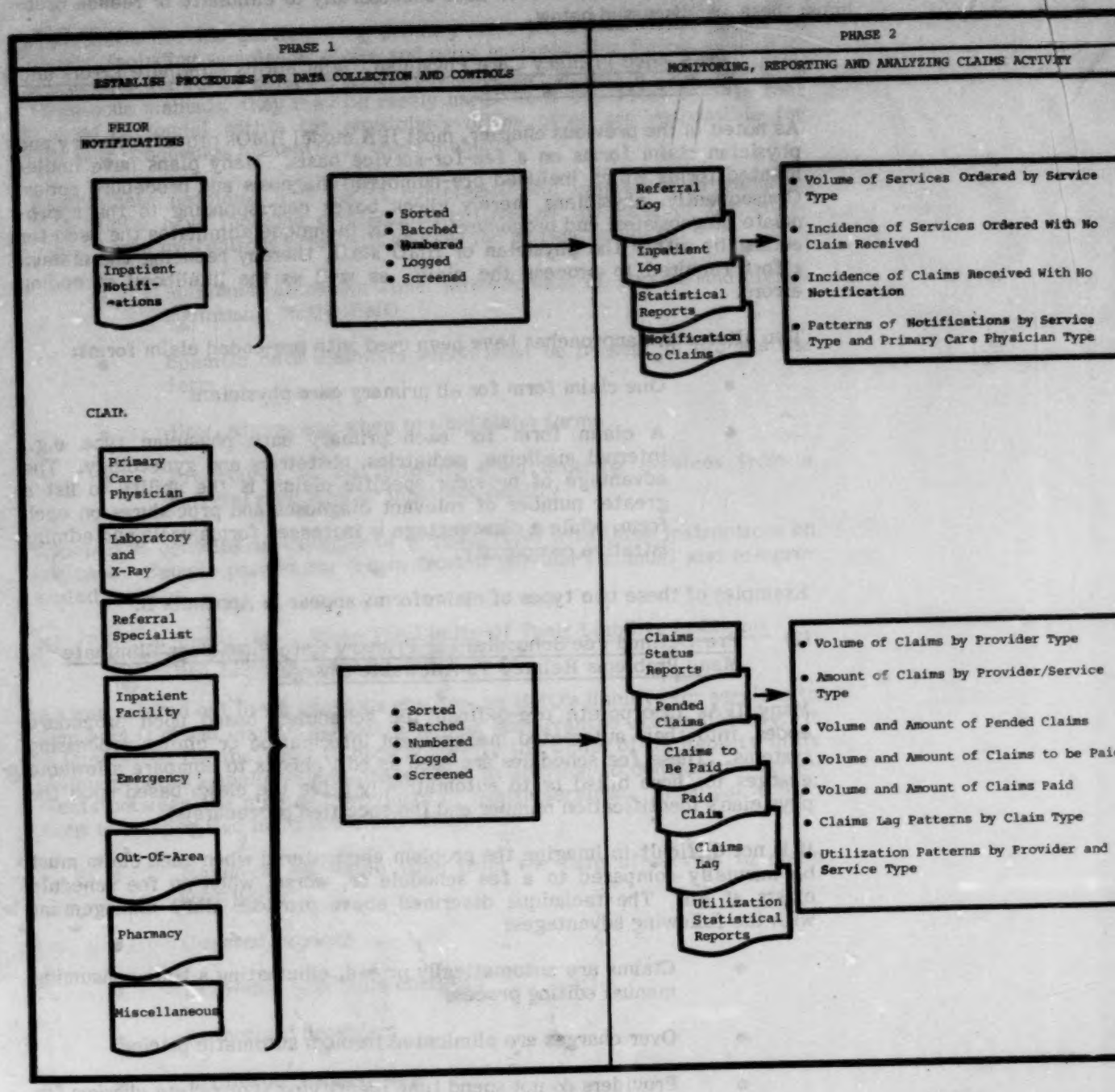

PHASE 1
ESTABLISH PROCEDURES FOR DATA COLLECTION AND CONTROLS
PHASE 2
MONITORING, REPORTING AND ANALYZING CLAIMS ACTIVITY
PRIOR NOTIFICATIONS
Inpatient Notifi-cations
Sorted
Batched
Numbered
Logged
Screened
Referral Log
Inpatient Log
Statistical Reports
Notification to Claims
Volume of Services Ordered by Service Type
Incidence of Services Ordered With No Claim Received
Incidence of Claims Received With No Notification
Patterns of Notifications by Service Type and Primary Care Physician Type
CLAIM
Primary Care Physician
Laboratory and X-Ray
Referral Specialist
Inpatient Facility
Emergency
Out-Of-Area
Pharmacy
Miscellaneous
Sorted
Batched
Numbered
Logged
Screened
Claims Status Reports
Pended Claims
Claims to Be Paid
Paid Claim
Claims Lag
Utilization Statistical Reports
Volume of Claims by Provider Type
Amount of Claims by Provider/Service Type
Volume and Amount of Pended Claims
Volume and Amount of Claims to be Pai
Volume and Amount of Claims Paid
Claims Lag Patterns by Claim Type
Utilization Patterns by Provider and Service Type

EXHIBIT II-2

CLAIMS LIABILITY
MANAGEMENT PROCESS PHASES

PHASE 3	PHASE 4
DEVELOPING CLAIMS LIABILITY DETERMINATIONS	RECORDING THE LIABILITY
Reported But Unpaid Claims • Estimate Value of Inhouse Claims By Claim Type • Analyze Historical Claims Lag Data, If Available	**Record Claims Liability Accrual** Debit - Medical Expense Credit - Claims Liabilities
Incurred But Not Reported Claims • Estimate Value of Referral Prior Notifications • Estimate Value of Inpatient Prior Notifications • Estimate Incidence of No Prior Notifications, e.g., emergencies • Analyze Claims Lag Reports To Determine Claims Run-off By Claim Type • Use Budgeted Claims Expenses and Approximations of Actual Experience in the Absence of Historical Data	

instructions is to assist providers in submitting forms that facilitate administrative processing by the HMO. Several techniques for forms design, instructions, and provider orientation have been used successfully to eliminate or reduce problems; these are discussed below.

(1) Pre-Coded Primary Care Physician Claim Forms Eliminate Errors and Reduce Processing Time

As noted in the previous chapter, most IPA model HMOs process primary and physician claim forms on a fee-for-service basis. Many plans have implemented forms which included pre-numbered diagnosis and procedure codes. Consequently, physicians merely check boxes corresponding to the appropriate diagnosis(es) and procedure(s). This technique eliminates the need for coding by either the physician or HMO staff, thereby reducing the manual effort required to process the claim, as well as the likelihood of coding errors.

Two alternative approaches have been used with pre-coded claim forms:

- One claim form for all primary care physicians
- A claim form for each primary care physician type e.g., internal medicine, pediatrics, obstetrics and gynecology. The advantage of provider specific claims is the ability to list a greater number of relevant diagnoses and procedures on each form, while a disadvantage is increased forms costs and administrative complexity.

Examples of these two types of claim forms appear in Appendix B.

(2) Pre-Defined Fee Schedules For Primary Care Physicians Eliminate Many Problems Related To Allowable Charges

Many IPAs incorporate pre-defined fee schedules, based upon procedure codes, into their automated management information or claims processing systems. These fee schedules are used as edit checks to compare allowable charges to those billed or to automatically price the claim based upon the physician's identification number and the specified procedure(s).

It is not difficult to imagine the problem encountered when each claim must be manually compared to a fee schedule or, worse, when no fee schedule exists at all. The technique described above provides HMO management with the following advantages:

- Claims are automatically priced, eliminating a time consuming manual editing process
- Over charges are eliminated through automatic pricing
- Providers do not spend time identifying appropriate charges for each claim form submitted

(3) Instructions For Claims Form Completion And Submission Appearing On The Form May Answer Questions From Physicians And Clerical Staff

Most HMOs provide participating primary care physicians with a provider manual, including samples of claim and prior authorization forms, as well as instructions for forms completion and submission. As is often the case with voluminous manuals, they may be rarely used. It is important to note that clerical personnel within the physician's office often are responsible for following procedures presented in these manuals.

To eliminate problems with forms completion and submission procedures, some HMOs have included printed instructions on the back of the claim form. These instructions often will address the critical issues of:

- Maximum allowable time between date of service and claims submission to the HMO
- Specific data elements which must be present to process the form
- How, where, and when to send claim forms
- Procedures to be followed when ordering services from a referral specialist or inpatient facility

Appendix B contains an example of a claim form with these instructions on the back. Sample procedures drawn from a provider's manual also are presented.

(4) HMOs Must Clearly State The Limits Of Their Liability In Claims Processing Policies And Procedures

As was pointed out in the previous chapter, an HMO's liability for services to members is broad enough without assuming unwarranted excess liability. It is imperative for the HMO to clearly specify the limits of its liability in its claims processing policies and procedures, in addition to contractual agreements between the plan and providers of health services. Principal limitations to be specified include the following:

- Maximum allowable time from the date of service to claim submission
- Covered services
- Allowable maximum charges
- Authorized providers
- Applicable co-payments
- Services requiring prior notification

These requirements should be set forth in the reimbursement agreements and contracts between the providers and the HMO to avoid disputes.

2. TECHNIQUES MUST BE USED TO FOSTER EFFECTIVE CLAIMS TRACKING

Exhibit II-3, following this page shows the flow of claim and prior notification data from provider to HMO. It also shows the principal steps required to manage these data. HMOs must identify and track each and every prior notification and claim from initial receipt, through various stages of the claims processing cycle. Exhibit II-4, following Exhibit II-3, shows the entire claims processing cycle. The following techniques have been employed successfully to foster effective claims tracking:

- Assignment of a unique number which denotes the date received through use of the Julian date (001 = January 1, 365 = December 31)
- Batching or grouping claims by claim type to facilitate organized flow through various processing stages
- Logging batches to monitor claims volume
- Identifying claims removed from batches during the processing cycle through use of an out-guide mechanism (such as is used with medical records)

These same techniques are employed in processing referral and inpatient notifications, as well as their resulting claims. Appendix B contains examples of claim and prior notification form:

- Numbering schemes
- Batching techniques
- Logging mechanisms
- Tracking procedures

Regardless of the particular mechanisms used, the goal remains rigorous control to avoid the problems of lost and misplaced claims or notifications.

PHASE 2: MONITORING, REPORTING, AND ANALYZING CLAIMS ACTIVITY

HMOs must monitor, report, and analyze fee-for-service claims and prior notifications to assure compliance with relevant policies and procedures. Also, plan management must compile sufficient data to permit analyses of the volume and patterns of these transactions both to identify the current liability and to project future liabilities. These issues are discussed in greater detail in the following sections.

EXHIBIT II-3

CLAIMS AND PRIOR NOTIFICATION FORMS FLOW

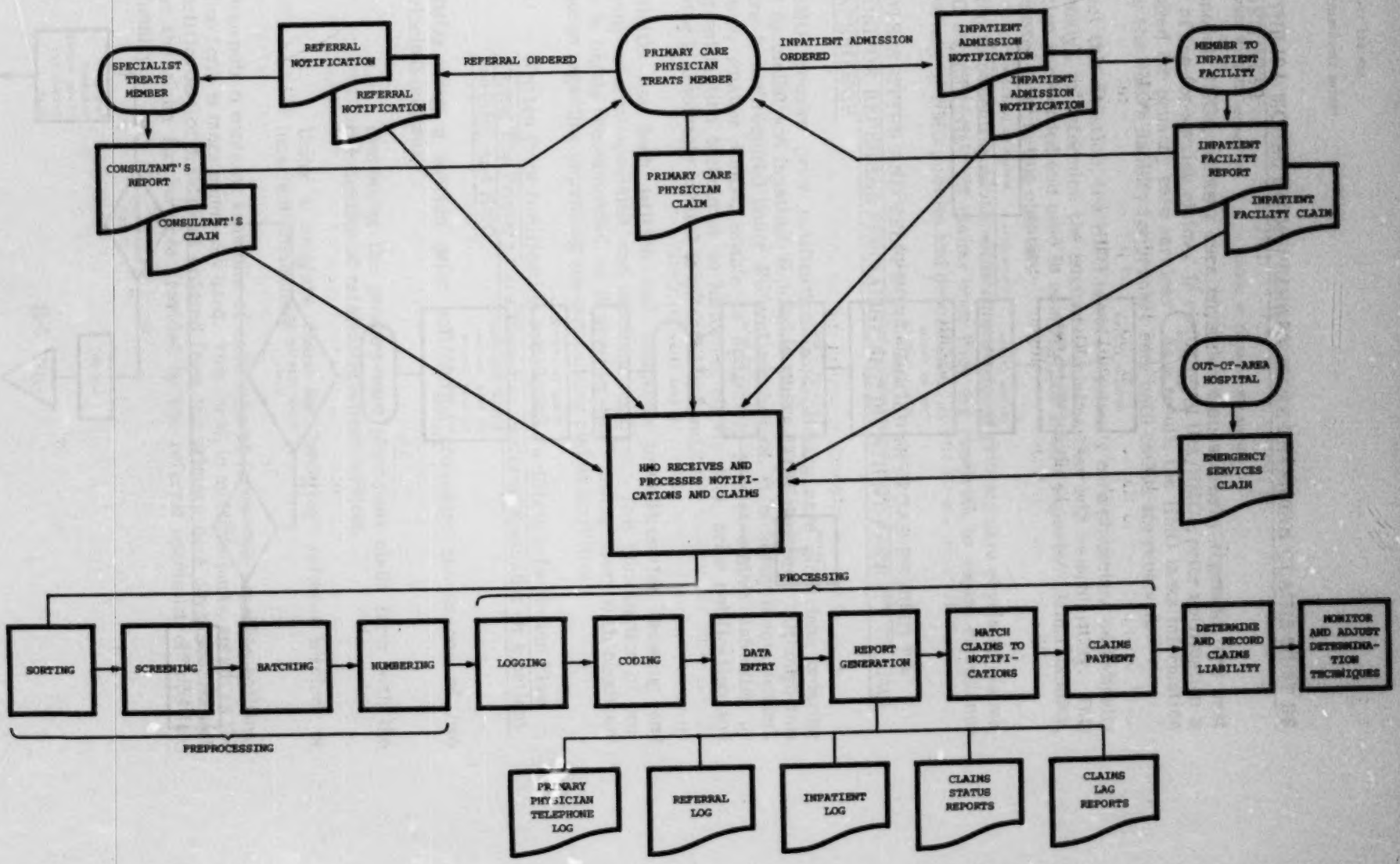
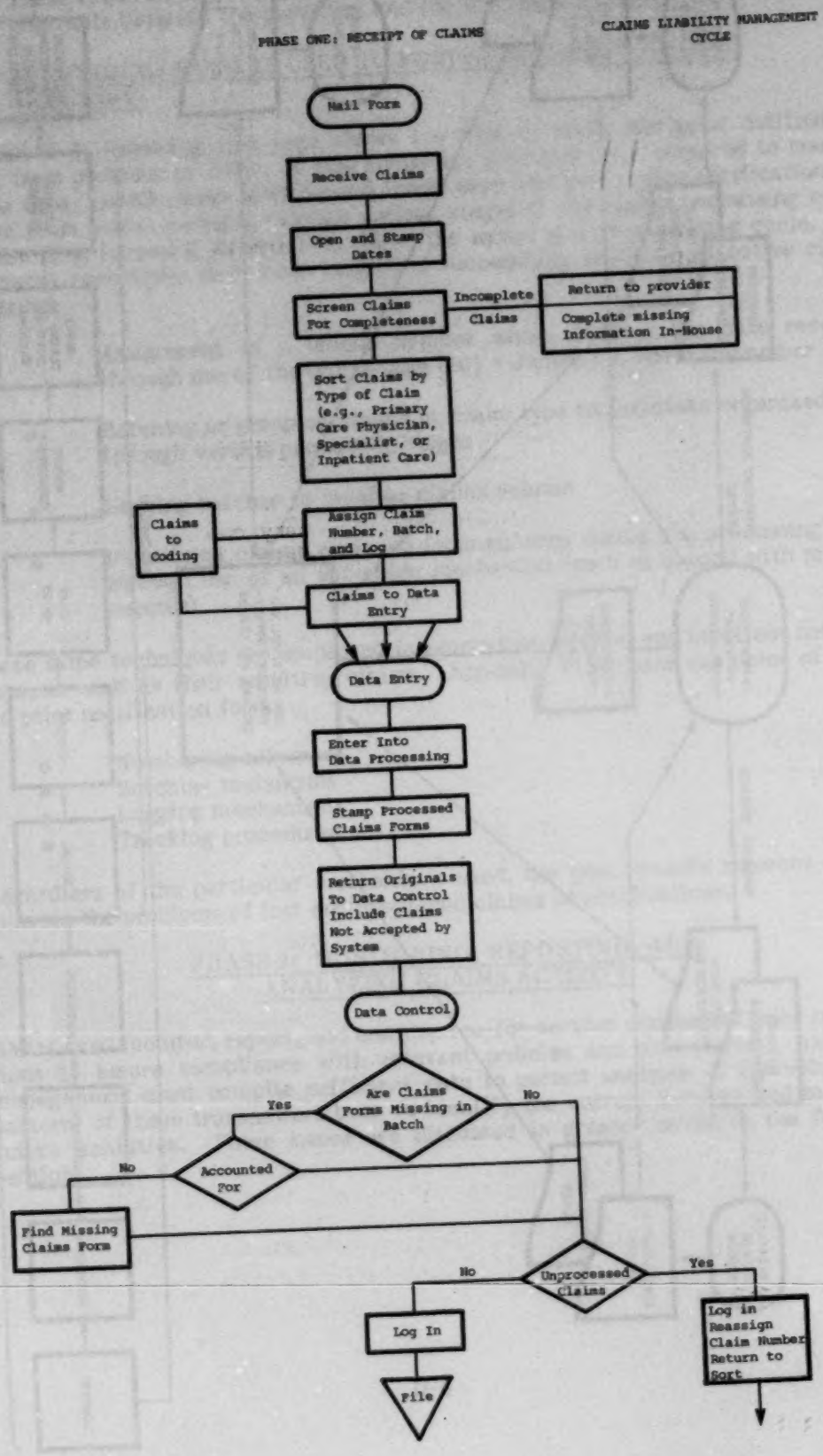


EXHIBIT II-4

CLAIMS PROCESSING CYCLE



1. IN THE IPA MODEL HMOs, PRIMARY CARE PHYSICIAN CLAIMS MUST BE MONITORED

In IPA model HMOs, primary care physician claims usually represent the vast majority of fee-for-service claims. In virtually all IPA/HMOs, prior notification is not required for primary care services. As a result, the HMO lacks information regarding the HMO's liability for primary care until claims are received.

To correct this situation, the HMO contacts primary care physicians periodically (e.g., weekly), to determine the number of claims they will be submitting. This information is recorded and used to compute the HMO's expected claims liability, as is discussed later in this chapter.

In addition to collecting advance information about primary care physician claims, the HMO should review all claims once they are received, to assure compliance with a variety of HMO policies and procedures.

2. BOTH WRITTEN AND TELEPHONE PROCEDURES CAN BE USED TO MONITOR REFERRAL SPECIALIST AND INPATIENT FACILITY CLAIMS EXPERIENCE

Most HMOs require prior notification from primary care physicians ordering referral specialist and inpatient admissions (and related services). Although this procedure is not required under Federal regulations, it is highly recommended. For newer, smaller HMOs, unable to accurately predict claims liabilities by applying estimation techniques to historical claims data, prior notification and monitoring is absolutely critical to effective control.

Many HMOs use both written and telephone procedures for ordering and monitoring referral specialist and inpatient services. This combination of procedures is highly recommended, as it provides HMO management with maximum information regarding impending and outstanding claims liabilities.

(1) Written Prior Notification Procedures Facilitate Information Flow Among The Primary Care Physician, Referral Specialist Or Inpatient Facility, And HMO

HMOs using a written prior notification procedure choose one of two principal options:

- Combining the primary care physicians claim form with the notification of referral/inpatient services
- Using a separate form for "ordering" referral services or inpatient admissions

Appendix B contains examples of each type of form. The separate notification form is more commonly used. This form, in multiple parts, serves as the notification of treatment ordered from the primary care physician, as well as the claim for services provided by the referral specialist or inpatient facility.

In this respect, the system functions as a purchase order system, with the prior notification serving as the purchase order, and the claim being the invoice. Consequently, the critical control point is the match between these two documents. The matching may be accomplished through manual or automated means.

Exhibit II-3, following page II-4, depicts the information and forms flow:

- From the primary care physician ordering service, to:
  - The referral specialist providing care
  - The HMO
- From this referral specialist providing care to the HMO

Referral notification procedures actually serve several purposes:

- Provide the referral specialists with written documentation to provide services
- Notify the specialist of the primary care physician's initial diagnosis or problem definition
- Alert the HMO's finance department to the impending liability
- Provide a mechanism to verify the primary care physician's ordering the specialist's services specified on the claim
- Provide a mechanism for monitoring primary care physician referral patterns and practices

The principal sequential steps in the referral process, also shown in Exhibit II-3, are:

- Completing the notification form and retaining a copy for the member's medical record by the primary care physician
- Forwarding copies of the form to both the specialist and the HMO's finance department where it is logged, serving as a purchase order
- Completing the claim form and consultant's report portions of the form by the referral specialist
- Returning copies of the consultant's report and claim form to the primary care physician and HMO finance department respectively, by the referral specialist
- Logging and batching the claim form(s), by the HMO
- Coding the diagnosis(es) and procedure(s), by the HMO if not done by the referral specialist

- Editing the claim form prior to and during data entry, by the HMO
- Matching the claim form to the prior notification, by the HMO, i.e., matching the invoice to the purchase order

Examples of referral notification procedures are presented in Appendix A.

(2) Telephone Procedures Should Be Used To Monitor Referral Specialist And Inpatient Services

It is recommended that HMOs use a telephone procedure to monitor actual experience regarding services provided by referral specialists and inpatient facilities. The purpose of the telephone procedure is to:

- Determine the status of ordered referrals/inpatient admissions
- Identify claims that the HMO will be receiving in the immediate future
- Identify unordered referrals or inpatient admissions
- Update the referral and inpatient admission logs

The telephone procedure suggested is comprised of the following activities:

- The primary care physician notifies HMO administration that a referral or inpatient admission has been authorized.
- HMO administration logs the referral or inpatient admission, including the referral or inpatient provider, number of visits ordered or anticipated length of stay, expected charges resulting from the referral or admission.
- HMO administration calls inpatient institutions daily and primary care and/or specialists about every two weeks to determine the status of each ordered visit or admission, as well as to identify any additional HMO members to whom services have been provided.
- HMO administration updates the referral and inpatient admission logs with information collected via the telephone calls.
- The HMO prepares weekly claims liability status reports that compare ordered referral and inpatient admission activity with actual experience determined through the telephone procedure described above.

An important aspect of the telephone procedure is identifying unordered referral and inpatient admissions or services. The individual responsible for making the telephone calls should notify the HMO's medical director of all instances in which service has been provided without required prior notification, in accordance with the HMO's claims processing policies and procedures.

The best way to implement this procedure is to assign responsibility for these activities to a single individual. In newer, smaller HMOs, this approach is quite practical. As the HMO grows, increased volume of referrals and inpatient admissions may necessitate more than one HMO staff person performing these activities.

In many HMOs using this telephone procedure, the individual(s) responsible for making (or receiving) the telephone calls often has a clinical training background, e.g., RN, LPN. Although this training is not required, it does facilitate communications between the staff person and health services providers. What is required, however, is an individual who demonstrates careful attention to detail and the ability to communicate in an affable manner.

(3) Once Received, Claims Must Be Edited And Monitored

As noted earlier, some plans utilize their automated management information system to perform certain editing and monitoring functions. For example, the following automated edits often are applied to determine the appropriateness of a given primary care physicians' claim in an IPA:

- Is the physician a participating primary care physician?
- Is the primary care physician submitting the claim the member's designated physician?
- Is the procedure being claimed appropriate or allowable based upon the physician's provider type?

Additional edits apply to both specialist and primary care claims. These include the following:

- Does the charge being claimed exceed the maximum allowed?
- Is the service (i.e., procedure code) covered in accordance with the member's coverage?
- Has any service limitation relative to quantity been met?
- Was the member eligible on the date of service?
- Is coordination of benefits available?
- Does the claim duplicate one previously submitted?

Whether performed on a manual or automated basis, these edits represent the principal criteria for determining the appropriateness of a claim and are not intended to represent an exhaustive list of all possible edit checks. There is, for example, a class of edits related to internal consistency of a claim which has not been discussed. This includes checks such as comparison of sex to diagnosis and procedure codes.

3. UTILIZATION PATTERNS SHOULD BE ANALYZED TO FOSTER CONTROL AND FACILITATE CLAIMS LIABILITY FORECASTING

Effective management of an HMO's claims liabilities is based upon the availability of accurate, timely, and comprehensive data. These data are generally categorized as follows:

- Aggregate statistical data showing the volume and cost of claims by provider category
- Detailed profiles of individual providers showing their claims history
- Claims status reports showing the stage of processing for all claims

Aggregate statistical reports are used to measure the actual service utilization rates, as compared to projected rates used to develop the budget. Typically, these reports identify utilization patterns and related costs by provider and service type including measurements such as:

- Number of visits/services for the month
- Year-to-date total visits/services
- Annualized utilization rates (per member per year, or per 1,000 members per year)
- Rate of utilization by demographic characteristics, e.g., age, sex
- Costs per member per month based upon current and year-to-date utilization statistics
- Utilization by subscriber grouping, e.g., Medicare, employer groups, Medicaid

Detailed provider profiles permit comparative analyses of the pattern of care among HMO providers. These reports generally include a detailed listing of all services provided and authorized by the individual physician. Consequently, provider profiles facilitate analyses such as:

- Compliance with prescribed treatment protocols
- Nature and extent of referral and inpatient services ordering practices
- Nature of the providers patient panel regarding the most common diagnoses

Claims status reports provide HMO management with critical information concerning the condition of claims both in aggregate, and on an individual basis. These reports are used in the following purposes:

- Identify the number and dollar value of claims at particular stages of the processing cycle, e.g., pended, to be paid

- Identify claims requiring research or follow-up
- Determine the work load and productivity of claims processing staff
- Identify the patterns of claims lag

Claims lag reports are a principal tool in estimating outstanding liabilities in an established HMO. This topic is discussed in Phase 3.

The reports and data described in this section are essential to both medical and administrative management of the HMO. To the plan's medical director, these reports are the principal tools for monitoring the activities and practice patterns of individual providers. They serve to identify providers falling outside established norms, as well as those performing in an exemplary manner. Also, these reports may serve as the basis for quality assurance committee activities and decisions.

For the HMO's financial management personnel, these reports are critical in monitoring actual performance as compared to budget assumptions and projections. For example, projected utilization rates are a principal variable in establishing capitation rates. Therefore, actual utilization rates must be carefully monitored to determine the adequacy of the capitation. It is also important for plan management to distinguish between variances in utilization rates versus those in unit costs to determine appropriate corrective actions.

PHASE 3: DETERMINING CLAIMS LIABILITIES

Although HMOs incur a liability at the time services are provided, they may not become aware of the exact cost of such service until sometime later. Accordingly, HMOs are forced to develop approximations of their liability for unrevealed fee-for-service claims. As discussed in Chapter I and shown in Exhibit I-2, an estimate or approximation of this liability must be recorded in the financial records to avoid misrepresentation of the HMO's true financial position.

An HMO's claims liabilities fall into two categories:

- **Reported But Unpaid Claims (RBUC)**—These claims have been received by the HMO, but not yet paid.
- **Incurred But Not Reported Claims (IBNR)**—These claims have not yet been received, although service has been provided.

Determining these liabilities is a financial management process that:

- Is comprised of specific activities
- Requires identifiable inputs
- Results in a quantifiable measure

Exhibit II-5, following this page, provides an overview of the liability determination process. The exhibit differentiates between HMOs having a historical data base, and those without. Generally, newer, smaller HMOs do not have a sufficient claims history to follow the process depicted on the top of Exhibit II-5. Based upon significant differences between plans in their liability determination processes and techniques, the discussion that follows is divided into two major sections:

- Determining claims liabilities in new, smaller HMOs
- Determining claims liabilities in older, larger HMOs

In these sections the following issues are discussed:

- Role of the HMO's prior notification and primary care physician telephone survey procedures
- Steps in the liability determination process
- Claims lag analysis as a tool in estimating claims liabilities
- Factors determining the appropriateness of particular estimating techniques

1. DETERMINING CLAIMS LIABILITIES WITHOUT SIGNIFICANT HISTORICAL CLAIMS DATA

Obviously, it is easiest and most sound to base claims liability determinations on data about the actual claims patterns. Unfortunately, many HMOs—generally new and small plans—do not have such data. Depending upon the plan's growth rate, one or more years of operation may be required to develop statistically sound claims lag reports to be used in estimating claims liabilities. Therefore, these HMO's must approach the liability determination process in a different manner.

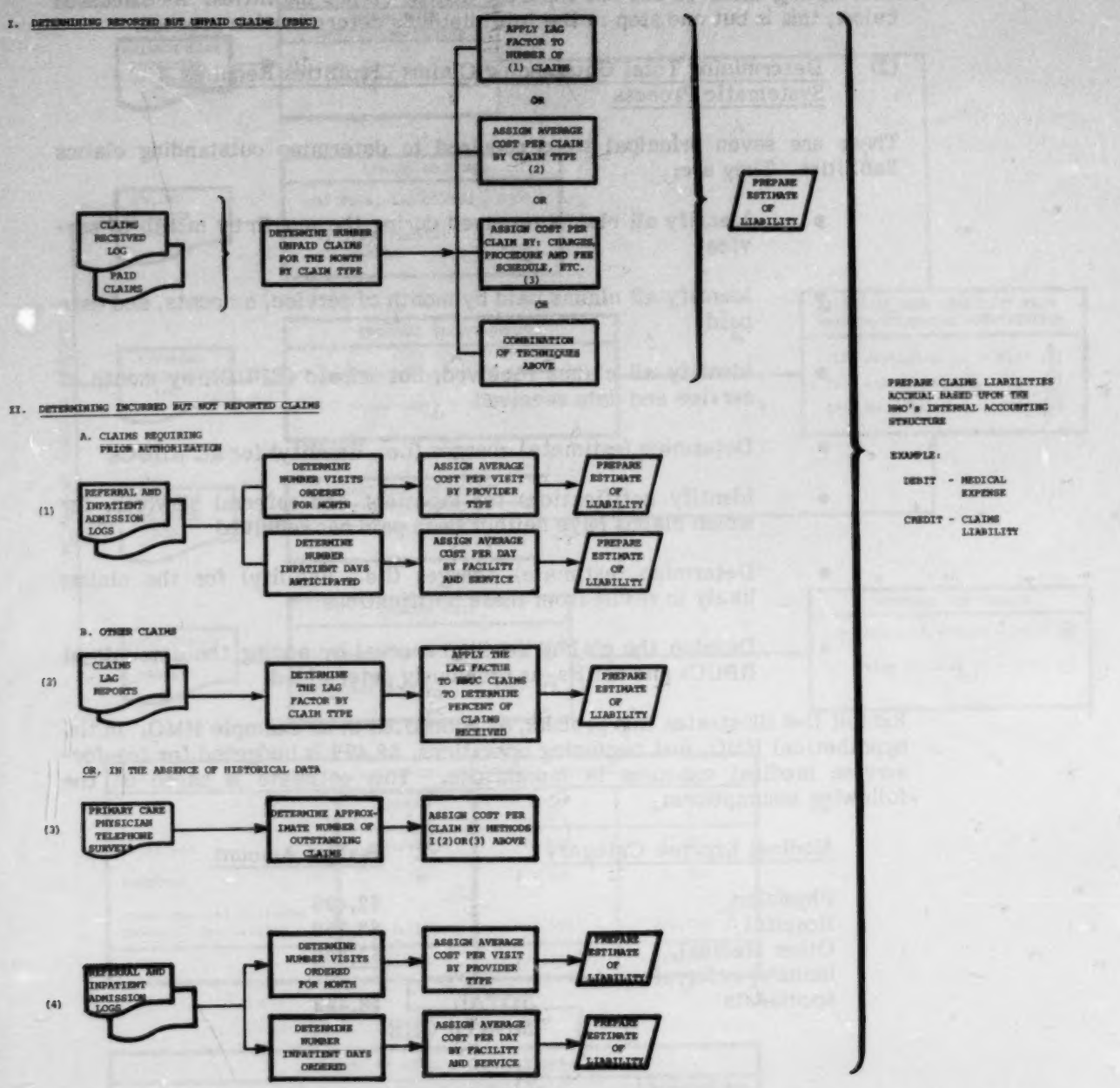
(1) Information Obtained From Written And Telephone Prior Notifications Is Used To Determine IBNR Claims Liabilities

As previously discussed, it is highly recommended that HMOs use a combination of written and telephone procedures to determine the number and anticipated costs of referral specialist and inpatient services. Information obtained through this procedure will be used to determine the HMOs liability for these services. This is accomplished by determining the anticipated cost to the HMO for each claim and accumulating these amounts for the period in question. The expected claim amount may be determined on the basis of fee schedules, past experience, hospital per diems, or other available information.

In IPA model HMOs, as previously discussed, a bi-weekly telephone survey is recommended to determine the number of outstanding primary care physician claims. This figure is used as the basis for calculating the liability amount. As with referral specialist and inpatient claims notification, each claim is assigned an expected amount based on the factors cited above.

EXHIBIT II-5

CLAIMS LIABILITY DETERMINATION PROCESS



* IPA and some group model HMOs

In this way, the HMO has developed an approximation or estimate of its outstanding incurred but not reported (IBNR) claims liabilities. As discussed below, this is but one step in the total liability determination process.

(2) Determining Total Outstanding Claims Liabilities Requires A Systematic Process

These are seven principal steps required to determine outstanding claims liabilities. They are:

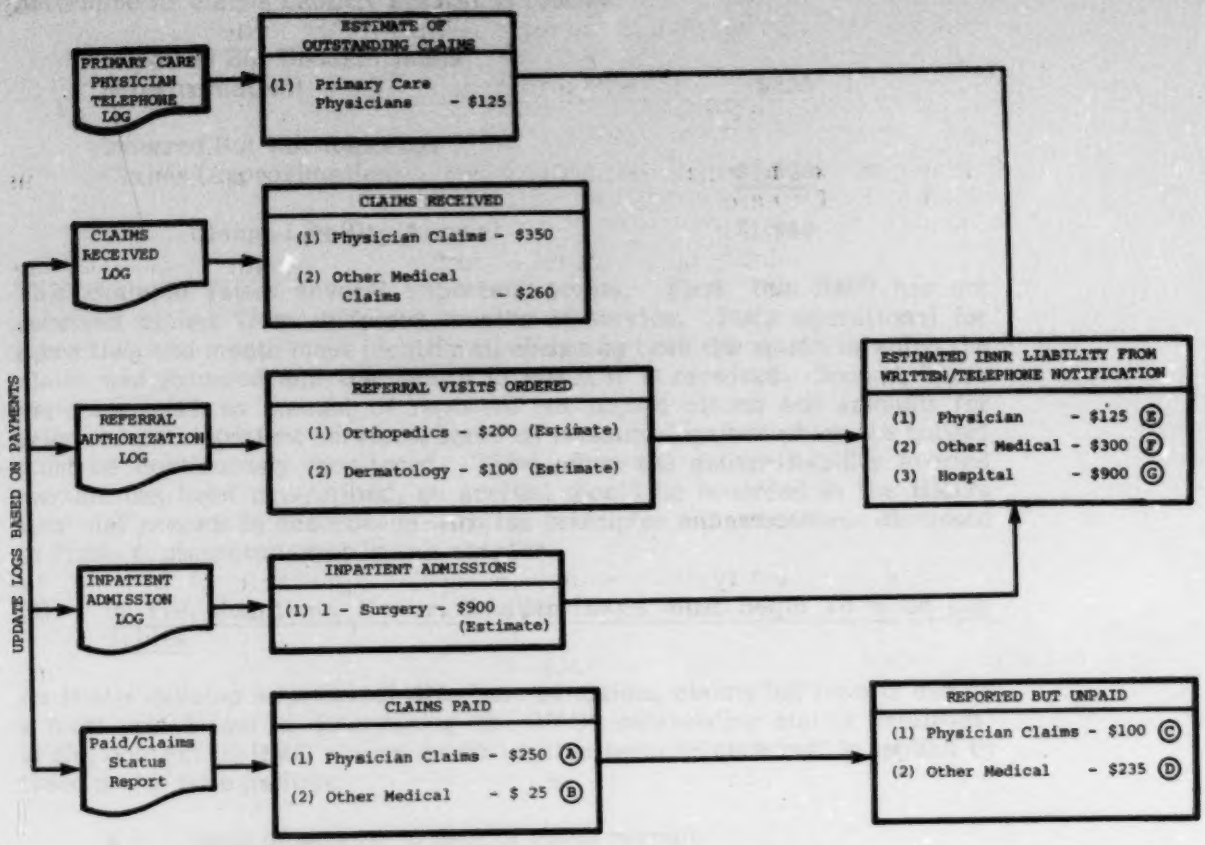
- Identify all claims received during the month by month of service
- Identify all claims paid by month of service, amounts, and date paid
- Identify all claims received, but unpaid (RBUC), by month of service and date received
- Determine (estimate) charges (i.e., liability) for all RBUCs
- Identify notifications for inpatient and referral services, for which claims have neither been paid nor received
- Determine (estimate) charges (i.e., liability) for the claims likely to result from these notifications
- Develop the claims liability accrual by adding the amounts of RBUCs and IBNRs, as previously determined

Exhibit II-6 illustrates this process, as conducted in an example HMO. In the hypothetical HMO, just beginning operations, $8,499 is budgeted for fee-for-service medical expenses in month one. This estimate is based on the following assumptions:

Medical Expense Category		Budget Amount
Physician		$2,499
Hospital		$3,750
Other Medical, includes referral specialists		$2,250
	TOTAL MONTH ONE	$8,499

EXHIBIT II-6

DETERMINING CLAIMS LIABILITIES
WITHOUT HISTORICAL DATA - EXAMPLE



BUDGETED FEE-FOR-SERVICE MEDICAL EXPENSES

	Month 1	Month 2	Month 3
Physician	$2,499	$4,998	$7,497
Hospital	3,750	7,500	11,250
Other Medical Includes Referral Specialists	2,250	4,500	6,750
TOTAL	$8,499	$16,998	$25,497

SUMMARY OF MONTH's TRANSACTIONS

Expense Category	Paid	Reported But Unpaid Claims	Budget	Incurred But Not Reported
Physician	$250 A	$100 C	$2,499	$125 E
Hospital	-0-	-0-	3,750	$900 G
Other Medical	25 B	235 D	2,250	$300 F
TOTAL	$275	$335	$8,499	$1,325

CLAIMS LIABILITY ACCRUAL = RBUCs + IBNRs
$335 + $1,325 = $1,660

11

Based on information contained in Exhibit II-7, the HMO in this example can determine its claims liability accrual as follows:

Reported But Unpaid Claims (Approximation)	-	$335
Incurred But Not Reported Claims (Approximation)	-	$1,325
Claims Liability Accrual		$1,660

This example raises several important points. First, this HMO has not received claims from different months of service. Plans operational for more than one month must identify all claims by both the month in which the claim was incurred and the month in which it is received. Second, these variables, such as amount of reported but unpaid claims and amounts for prior ordered inpatient services, serve as measures against which the budget must be continuously monitored. Third, once the claims liability accrual amount has been determined, an accrual should be recorded in the HMO's financial records in accordance with the principles and procedures discussed in Phase 4, presented later in this chapter.

(3) In The Meantime, Newer, Smaller HMOs Must Begin To Build Lag Tables

As HMOs develop a historical data base of claims, claims lag reports can be a most useful tool in determining the HMO's outstanding claims liabilities. In the context of HMO claims liabilities, the term "claims lag" is applied to three major time periods:

- Date of service to date of claim receipt
- Date of claim receipt to date paid
- Date of service to date paid

An example of these lag periods is shown below:

A.	Date of Service (May 1, 1980)	To	Date Claim Received (May 20, 1980)
		19 days	
B.	Date Claim Received (May 20, 1980)	To	Date Claim Paid (June 10, 1980)
		21 days	
C.	Date of Service (May 1, 1980)	To	Date Claim Paid (June 10, 1980)

40 Days (19 + 21)

Analysis of each of the these lag periods provides HMO management with crucial information. The first lag period (date of service to date claim received) denotes the speed with which claims are submitted to the HMO from providers. It is imperative that the plan monitor and document this pattern for major provider categories such as primary care physician (in the case of IPA/HMOs), specialists, hospitals, laboratories. The extent to which these patterns vary among provider categories has direct implications for the liability estimation process. Monitoring the claims submission pattern of providers also will permit enforcement of HMO policies regarding maximum allowable times for claims submission.

The second lag period (date claim received to date paid) is the one over which the HMO can exercise considerable control. This time period denotes the efficiency or timeliness with which claims are processed from receipt to payment. These data should be arrayed by provider category, to determine variance in processing time across claim types and the potential impact on the HMO's short-term cash needs. In some HMOs, this lag period is defined as the time from claim receipt to "processing," i.e., the date when the claim may be paid, as compared to actual date of payment (i.e., check date).

The third lag period (date of service to date claim paid), the sum of the two previous time periods (lags), has a major impact on cash needs assessment and estimating incurred but not reported claims liabilities. This time period is known as the "run-off."

Exhibit II-7, following this page, is a sample claims lag report. In this sample report, physician, hospital outpatient, and hospital inpatient claims are shown on separate pages of the report. While the format of these reports may vary across HMOs, the data displayed should be comparable. There will be differences, however, between IPA/HMOs and staff or some group models, due to differences in their scope of fee-for-service claims (i.e., primary care physicians) and reserve requirements.

Exhibit II-8, following Exhibit II-7, demonstrates the interrelationship between the three lag periods. It also serves as an example of the quantitative interrelationships between these variables. It is important to remember that each report measures a different variable. Methods for applying these measures to estimate liabilities are discussed and demonstrated by example in the section covering older, larger HMOs.

(4) <u>As The HMO Develops Historical Claims Data, Liability Determination Techniques Will Change</u>

It is difficult, if not impossible, to specify the precise point at which an HMO should adopt alternative liability determination techniques. Several principles, however, should be followed:

- Even the smallest, newest HMOs must begin to collect and lag compile actual claims experience data in the form of lag reports

- Patterns of claims lag should be analyzed to determine the point at which stable patterns become discernable

EXHIBIT II-7(1)

SAMPLE CLAIMS LAG REPORT

CLAIMS LAG REPORT FROM DATE OF SERVICE TO DATE PAID
PHYSICIANS SERVICES

	PHYSICIANS SERVICES			HOSPITAL OUTPATIENT			HOSPITAL INPATIENT			TOTAL MEDICAL SERVICES							
	#	%	AMOUNT CLAIMED	#	%	AMOUNT CLAIMED	#	%	AMOUNT CLAIMED	#	%	AMOUNT CLAIMED	CO-PAY AMOUNT	DISALW AMOUNT	RESERVE AMOUNT	AMOUNT PAYABLE	AMOUNT PAID
07/80	1875	43.52	77401	0	0.00	0	0	0.00	0	1875	43.52	77401	0	5936	10223	125	61118
1ST	1462	34.40	83766	0	0.00	0	0	0.00	0	1462	34.40	83766	270	8347	10120	113	65137
2ND	463	10.75	29392	0	0.00	0	0	0.00	0	463	10.75	29392	0	5973	3517	92	21810
3RD	196	4.55	16477	0	0.00	0	0	0.00	0	196	4.55	16477	0	2503	1921	293	11859
4TH	78	1.81	7047	0	0.00	0	0	0.00	0	78	1.81	7047	0	1699	763	121	4665
5TH	174	4.04	10702	0	0.00	0	0	0.00	0	174	4.04	10702	0	983	1537	2559	6673
6TH+	40	0.93	4219	0	0.00	0	0	0.00	0	40	0.93	4219	0	123	555	530	3041
TOTAL	4305		229004	0		0	0		0	4305		229004	270	23564	28505	3833	174152
08/80	1968	45.10	79829	0	0.00	0	0	0.00	0	1968	45.10	79829	0	7279	10275	133	62143
1ST	1654	37.90	91929	0	0.00	0	0	0.00	0	1654	37.90	91929	30	9889	11281	758	70001
2ND	383	8.78	38217	0	0.00	0	0	0.00	0	383	8.78	38217	50	5124	6494	739	20350
3RD	148	3.39	12284	0	0.00	0	0	0.00	0	148	3.39	12284	0	1915	1503	0	8866
4TH	153	3.51	7592	0	0.00	0	0	0.00	0	153	3.51	7592	0	978	992	35	5587
5TH	58	1.33	2539	0	0.00	0	0	0.00	0	58	1.33	2539	0	156	310	795	1278
6TH+	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
TOTAL	4364		224390	0		0	0		0	4364		224390	80	25340	27856	2459	168735
09/80	2269	48.99	91607	0	0.00	0	0	0.00	0	2269	48.99	91607	10	6667	11960	21	72959
1ST	1593	34.39	93430	0	0.00	0	0	0.00	0	1593	34.39	93430	10	9116	11234	224	72803
2ND	367	7.92	29956	0	0.00	0	0	0.00	0	367	7.92	29956	90	4863	3522	0	21572
3RD	273	5.89	18205	0	0.00	0	0	0.00	0	273	5.89	18205	30	3095	2065	1641	11404
4TH	130	2.81	9916	0	0.00	0	0	0.00	0	130	2.81	9916	0	307	1278	2833	5498
5TH	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
6TH+	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
TOTAL	4632		243113	0		0	0		0	4632		243113	140	24046	30113	4718	184236
10/80	3596	49.38	135800	0	0.00	0	0	0.00	0	3596	49.38	135800	0	11878	17972	2102	103931
1ST	2409	33.08	139711	0	0.00	0	0	0.00	0	2409	33.08	139711	0	20973	16384	409	101945
2ND	967	13.28	71348	0	0.00	0	0	0.00	0	967	13.28	71348	90	8756	8708	2141	51742
3RD	310	4.26	25994	0	0.00	0	0	0.00	0	310	4.26	25994	0	1381	4452	13502	13238
4TH	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
5TH	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
6TH+	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
TOTAL	7282		372853	0		0	0		0	7282		372853	90	42989	47515	18154	270756
11/80	3879	49.10	141413	0	0.00	0	0	0.00	0	3879	49.10	141413	0	15323	18146	646	107333
1ST	3275	41.46	155033	0	0.00	0	0	0.00	0	3275	41.46	155033	0	16355	10968	4161	115570
2ND	746	9.44	56280	0	0.00	0	0	0.00	0	746	9.44	56280	0	4727	7392	12611	31859
3RD	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
4TH	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
5TH	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
6TH+	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
TOTAL	7900		352726	0		0	0		0	7900		352726	0	36385	44505	17418	254763

EXHIBIT II-7(2)

CLAIMS LAG REPORT FROM DATE OF SERVICE TO DATE PAID
HOSPITAL OUTPATIENT SERVICES

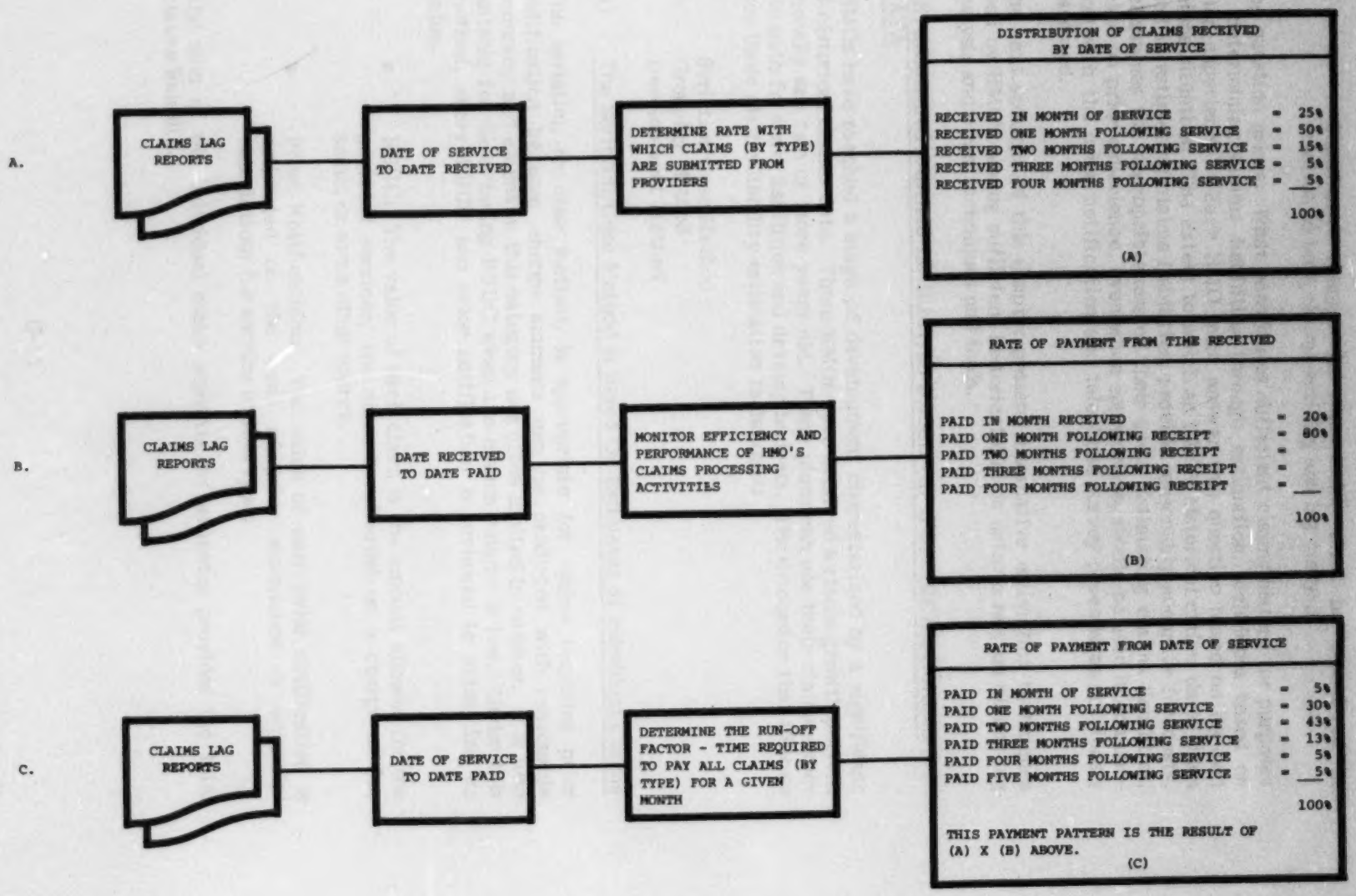
	PHYSICIANS SERVICES			HOSPITAL OUTPATIENT			HOSPITAL INPATIENT			TOTAL MEDICAL SERVICES							
	#	%	AMOUNT CLAIMED	#	%	AMOUNT CLAIMED	#	%	AMOUNT CLAIMED	#	%	AMOUNT CLAIMED	CO-PAY AMOUNT	DISALW AMOUNT	RESERVE AMOUNT	AMOUNT PAYABLE	AMOUNT PAID
02/80	0	0.00	0	41	41.84	3078	0	0.00	0	41	41.84	3078	0	64	0	0	3014
1ST	0	0.00	0	40	40.82	4669	0	0.00	0	40	40.82	4669	0	0	0	0	4669
2ND	0	0.00	0	5	5.10	299	0	0.00	0	5	5.10	299	0	20	0	0	279
3RD	0	0.00	0	8	8.16	323	0	0.00	0	8	8.16	323	0	19	0	0	304
4TH	0	0.00	0	2	2.04	119	0	0.00	0	2	2.04	119	0	0	0	0	119
5TH	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
6TH+	0	0.00	0	2	2.04	103	0	0.00	0	2	2.04	103	0	28	0	0	75
TOTAL	0		0	98		8591	0		0	98		8591	0	131	0	0	8460
03/80	0	0.00	0	63	42.86	6007	0	0.00	0	63	42.86	6007	0	113	0	0	5894
1ST	0	0.00	0	67	45.58	5311	0	0.00	0	67	45.58	5311	0	31	0	0	5280
2ND	0	0.00	0	8	5.44	1722	0	0.00	0	8	5.44	1722	0	102	0	0	1619
3RD	0	0.00	0	4	2.72	426	0	0.00	0	4	2.72	426	0	45	0	0	381
4TH	0	0.00	0	1	0.68	35	0	0.00	0	1	0.68	35	0	0	0	0	35
5TH	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
6TH+	0	0.00	0	4	2.72	455	0	0.00	0	4	2.72	455	0	0	0	0	455
TOTAL	0		0	147		13956	0		0	147		13956	0	292	0	0	13665
04/80	0	0.00	0	69	43.40	5387	0	0.00	0	69	43.40	5387	0	47	0	0	5341
1ST	0	0.00	0	61	38.36	5353	0	0.00	0	61	38.36	5353	0	175	0	0	5178
2ND	0	0.00	0	11	6.92	1404	0	0.00	0	11	6.92	1404	0	5	0	0	1399
3RD	0	0.00	0	2	1.26	75	0	0.00	0	2	1.26	75	0	0	0	0	75
4TH	0	0.00	0	7	4.40	445	0	0.00	0	7	4.40	445	0	0	0	0	445
5TH	0	0.00	0	2	1.26	103	0	0.00	0	2	1.26	103	0	81	0	0	22
6TH+	0	0.00	0	7	4.40	331	0	0.00	0	7	4.40	331	0	22	0	0	309
TOTAL	0		0	159		13099	0		0	159		13099	0	330	0	0	12768
05/80	0	0.00	0	110	38.73	11308	0	0.00	0	110	38.73	11308	0	243	0	0	11065
1ST	0	0.00	0	134	47.18	9644	0	0.00	0	134	47.18	9644	0	493	0	0	9151
2ND	0	0.00	0	18	6.34	1382	0	0.00	0	18	6.34	1382	0	240	0	0	1143
3RD	0	0.00	0	7	2.46	519	0	0.00	0	7	2.46	519	0	163	0	0	356
4TH	0	0.00	0	4	1.41	411	0	0.00	0	4	1.41	411	0	149	0	0	262
5TH	0	0.00	0	7	2.46	291	0	0.00	0	7	2.46	291	0	70	0	0	221
6TH+	0	0.00	0	4	1.41	247	0	0.00	0	4	1.41	247	0	55	0	39	154
TOTAL	0		0	284		23802	0		0	284		23802	0	1413	0	39	22351
06/80	0	0.00	0	188	42.53	15756	0	0.00	0	188	42.53	15756	0	363	0	0	15393
1ST	0	0.00	0	182	41.18	19189	0	0.00	0	182	41.18	19189	0	1064	0	0	18125
2ND	0	0.00	0	37	8.37	2918	0	0.00	0	37	8.37	2918	0	459	0	0	2359
3RD	0	0.00	0	15	3.39	2122	0	0.00	0	15	3.39	2122	0	25	0	0	2097
4TH	0	0.00	0	3	1.81	426	0	0.00	0	3	1.81	426	0	46	0	0	380
5TH	0	0.00	0	5	1.13	450	0	0.00	0	5	1.13	450	0	36	0	0	414
6TH+	0	0.00	0	7	1.58	937	0	0.00	0	7	1.58	937	0	46	0	0	891
TOTAL	0		0	442		41698	0		0	442		41698	0	2040	0	0	39658

CLAIMS LAG REPORT FROM DATE OF SERVICE TO DATE PAID
HOSPITAL INPATIENT SERVICES

	PHYSICIANS SERVICES			HOSPITAL OUTPATIENT			HOSPITAL INPATIENT			TOTAL MEDICAL SERVICES							
	#	%	AMOUNT CLAIMED	#	%	AMOUNT CLAIMED	#	%	AMOUNT CLAIMED	#	%	AMOUNT CLAIMED	CO-PAY AMOUNT	DISALW AMOUNT	RESERVE AMOUNT	AMOUNT PAYABLE	AMOUNT PAID
02/80	0	0.00	0	0	0.00	0	7	35.00	9299	7	35.00	9299	0	178	0	0	9121
1ST	0	0.00	0	0	0.00	0	11	55.00	22557	11	55.00	22557	0	84	0	0	22474
2ND	0	0.00	0	0	0.00	0	1	5.00	18353	1	5.00	18353	0	63	0	0	18290
3RD	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
4TH	0	0.00	0	0	0.00	0	1	5.00	392	1	5.00	392	0	0	0	0	392
5TH	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
6TH+	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
TOTAL	0		0	0		0	20		50601	20		50601	0	324	0	0	50276
03/80	0	0.00	0	0	0.00	0	17	47.22	24771	17	47.22	24771	0	3999	0	0	20772
1ST	0	0.00	0	0	0.00	0	17	47.22	30028	17	47.22	30028	0	263	0	0	29765
2ND	0	0.00	0	0	0.00	0	1	2.78	2624	1	2.78	2624	0	0	0	0	2624
3RD	0	0.00	0	0	0.00	0	1	2.78	110	1	2.78	110	0	0	0	0	110
4TH	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
5TH	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
6TH+	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
TOTAL	0		0	0		0	36		57533	36		57533	0	4261	0	0	53271
04/80	0	0.00	0	0	0.00	0	14	32.56	12294	14	32.56	12294	0	127	0	0	12167
1ST	0	0.00	0	0	0.00	0	19	44.19	30488	19	44.19	30488	0	4820	0	0	25668
2ND	0	0.00	0	0	0.00	0	6	13.95	18073	6	13.95	18073	0	167	0	0	17906
3RD	0	0.00	0	0	0.00	0	3	6.98	1848	3	6.98	1848	0	270	0	0	1578
4TH	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
5TH	0	0.00	0	0	0.00	0	1	2.33	1125	1	2.33	1125	0	125	0	0	1000
6TH+	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
TOTAL	0		0	0		0	43		63828	43		63828	0	5509	0	0	58319
05/80	0	0.00	0	0	0.00	0	12	23.08	10239	12	23.08	10239	0	177	0	0	10063
1ST	0	0.00	0	0	0.00	0	29	55.77	45889	29	55.77	45889	0	427	0	0	45463
2ND	0	0.00	0	0	0.00	0	2	3.85	16380	2	3.85	16380	0	199	0	0	16181
3RD	0	0.00	0	0	0.00	0	4	7.69	21088	4	7.69	21088	0	1207	0	0	19860
4TH	0	0.00	0	0	0.00	0	3	5.77	2369	3	5.77	2369	0	12	0	0	2357
5TH	0	0.00	0	0	0.00	0	1	1.92	81	1	1.92	81	0	0	0	0	31
6TH+	0	0.00	0	0	0.00	0	1	1.92	1241	1	1.92	1241	0	1241	0	0	0
TOTAL	0		0	0		0	52		97287	52		97287	0	3262	0	0	94025
06/80	0	0.00	0	0	0.00	0	21	23.33	24289	21	23.33	24289	0	370	0	0	23919
1ST	0	0.00	0	0	0.00	0	48	53.33	76730	48	53.33	76730	0	3442	0	0	73288
2ND	0	0.00	0	0	0.00	0	10	11.11	28009	10	11.11	28009	0	17078	0	0	10931
3RD	0	0.00	0	0	0.00	0	7	7.78	10041	7	7.78	10041	0	7865	0	0	2176
4TH	0	0.00	0	0	0.00	0	2	2.22	11716	2	2.22	11716	0	6313	0	0	5402
5TH	0	0.00	0	0	0.00	0	2	2.22	5629	2	2.22	5629	0	5629	0	0	0
6TH+	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0	0	0	0	0	0
TOTAL	0		0	0		0	90		156413	90		156413	0	40697	0	0	115715

EXHIBIT II-8

SAMPLE CLAIMS LAG MEASUREMENTS



- Significant changes in membership must be considered in relation to both claims activity and lag analysis

The question arises: What constitutes sufficient claims history for purposes of determining claims liabilities through estimation techniques based on prior experience? Each HMO must answer this question based on its own unique situation. The extent to which an HMO's historical claims data, when used in estimating claims liabilities, provide reasonably accurate forecasts, determines the appropriateness of their use. Estimating claims liabilities, based on prior experience, even when appropriate, should be used in conjunction with the prior notification and telephone survey procedures previously discussed.

The next sections of this chapter present alternative estimation techniques used by HMO's having sufficient historical claims data to rely on claims lag analysis and other techniques and tools.

2. DETERMINING CLAIMS LIABILITIES BASED ON HISTORICAL CLAIMS DATA

Many HMOs have reached a stage of development characterized by a significant body of historical claims data. These HMOs have attained a stable growth pattern and generally are two or more years old. These plans can use their claims experience to both forecast liabilities and develop budgets. The discussion that follows addresses three claims liability estimation techniques:

- Seriatim/Case Method
- Grouping Method
- Development Method

(1) The Seriatim/Case Method Is Based On Estimates of Individual Claims

The seriatim, or case method, is appropriate for claims requiring prior notification because charge amounts can be predicted with reasonable accuracy and claims in this category are often limited in number. It is also suitable for determining RBUC when the claims volume is low. Under this method, every RBUC and prior notification is reviewed to determine its value.

- RBUC: The value of each claim is the amount allowed for the provided services, the amount reflected on a charge or fee scale, or some other source.

- Prior Notifications: The value of each prior notification is estimated on the basis of prior experience or actuarial calculations for service of that type.

The sum of the individual claim amounts or estimates provides the total claims liability.

For example, an estimate of hospitalization charges for a given stay may be derived by multiplying the cost per day of the hospital by the estimated length of stay for that admission. Based on the diagnosis, factors regarding surgical procedures, anesthesia, and other charges may be added to the estimate.

The seriatim method requires analysis of each claim or prior notification on an individual basis. This method does not require significant historical data, but is only practical with relatively low volume transactions. As volume increases, an HMO will find it practical to adopt the grouping method discussed next.

(2) The Grouping Method Is Based On Average Charges By Claim Type

In this method, the HMO groups its RBUC and prior notifications into groups, and then estimates the liability for each group based on:

- The average cost for a claim of that type, multiplied by
- The number of claims in the group.

This method of estimation relies on historical data, fee schedules, and contracts to determine the average charge for a category (group) of claims. The accuracy of this method depends on the appropriateness of groups. Groups should be homogeneous to minimize the variance in cost per claim.

For example, prior notifications would be grouped by type of service, e.g., allergy, orthopedic surgery, dermatology, etc. The average cost per visit, by service type, would be multiplied by the number of visits represented in the notifications.

Like the seriatim method, this method is appropriate for RBUC claims (since one can count their actual number) and prior notifications (which also can be counted individually). It is especially useful when the claims volume is too large to make the seriatim method practical. Use of this method requires monitoring the actual average cost of claims by group and periodic adjustments to the estimation factor, as may be required.

(3) The Development Method Uses Historical Lag Tables And Is Most Appropriate For Estimating IBNR Claims Liabilities

The development method of estimating claims liabilities is somewhat more complex than the seriatim or group methods. This approach is used by HMOs, generally the older and larger plans, with reliable lag tables to estimate IBNR claims liabilities. The example that follows illustrates the use of the development estimation method.

Assume that the lag factors presented earlier in Exhibit II-8 were derived from an HMO's lag tables comprised of data covering two years. These factors represent the averages across all months. The calculations that follow demonstrate the estimation process for this hypothetical HMO:

Claims Activity

(a) Claims Received For Service During Current Month: $50,000

(b) Claims Paid For Service In Current Month: $2,500

Lag Factors

(c) Percent Of Claims Received In Month Of Service: 25 percent

(d) Percent Of Claims Paid In Month Received: 20 percent

(e) Percent Of Claims Paid In Month Of Service: 5 percent

Claims Liability Accrual Estimate

1. (a) x (c) — Claims For Service In Current Month Percent Of Claims Received In Month Of Service

(a) = $50,000
(c) = 25 Percent

$50,000 = 25% Of The Month's Total Claims Expense
$50,000 = 25% of $200,000

2. Estimated Total Claims Expense ($200,000) - (b) Claims Paid ($2,500) = $197,500 Claims Liability Accrual

Several important points must be made regarding this example and use of the development method, in general. First, the accuracy of this method depends on a reliable and stable claims lag pattern. Exhibit II-9, following this page, commonly know as a "triangle chart," shows total payments, by months, against the month of incurral, i.e., service. In months for which 100 percent of payments have not been made yet (July 1979—January 1980), the percent of total (shown in parenthesis) is derived from an estimate of total claims expenses.

This table shows a very stable claims lag pattern generally characteristic of larger more established HMOs. Factors affecting claims lag patterns are numerous. Across HMOs, factors such as these result in different lag patterns:

- Local provider practices in submitting claims
- Different payment cycles
- Different claims payment systems
- Prior notification practices and procedures

EXHIBIT II-9

ILLUSTRATIVE DEVELOPMENT OF INCURRED BUT NOT REPORTED CLAIMS LIABILITY

YEAR	MONTH	CLAIMS PAYMENTS BY MONTH TOTAL MONTHLY PAYMENT	Distribution of Physicians Claim Payments by Month Incurred Prior to January 1979	1979 January	1979 February	1979 March	1979 April	1979 May	1979 June	1979 July	1979 August	1979 September	1979 October	1979 November	1979 December	1980 January
1979	January	$191,100	$187,180	3,920 2%												
	February	199,260	154,098	43,120 24%	2,042 1%											
	March	199,200	97,209	54,880 52%	40,836 21%	6,275 3%										
	April	208,213	44,696	41,160 73%	69,421 55%	50,198 27%	2,738 1%									
	May	204,411	39,598	29,400 88%	26,543 68%	64,840 58%	42,525 22%	1,505 1%								
	June	211,918	16,589	11,760 94%	34,711 85%	41,832 78%	54,675 49%	44,528 23%	7,823 1%							
	July	209,806	2,147	7,840 98%	6,247 88%	25,099 90%	62,775 80%	60,720 53%	41,072 25%	3,906 (2%)						
	August	207,510	3,910	2,208 99%	6,003 91%	18,824 99%	18,225 89%	58,696 82%	50,850 51%	44,924 (25%)	3,870 (2%)					
	September	190,752	1,922	- 99%	10,209 96%	- 99%	12,150 95%	18,216 91%	46,939 75%	54,690 (53%)	42,570 (24%)	4,056 (2%)				
	October	211,218	-	1,712 100%	4,084 98%	2,092 100%	8,100 99%	16,192 99%	23,470 87%	48,830 (78%)	58,050 (54%)	44,616 (24%)	4,072 (2%)			
	November	192,398	817	- 100%	2,228 99%	- 100%	- 99%	- 99%	13,691 94%	19,532 (88%)	48,375 (79%)	58,812 (53%)	44,788 (24%)	4,155 (2%)		
	December	212,490	-	-	1,856 100%	-	1,312 100%	2,543 100%	9,779 99%	17,579 (97%)	17,828 (88%)	52,728 (79%)	59,038 (53%)	45,709 (24%)	4,118 (2%)	
1980	January	202,151	-	Ⓐ -	- 100%	-	- 100%	- 100%	1,956 100%	2,154 (98%)	17,002 (97%)	20,280 (89%)	50,895 (78%)	60,253 (53%)	45,302 (24%)	4,309 (2%)
Total Claims Paid to Date				$196,000	$204,180	$209,160	$202,500	$202,400	$195,580	$191,615	$187,695	$180,492	$158,793	$110,117	$ 49,420	$ 4,309

Ⓐ - Vertical columns demonstrate the run-off for a given month's incurred expenses, with the percent of the month's total shown under each month of payment.

Ⓑ - Viewing the table diagonally, the consistency of the percent paid in the month of incurral becomes evident. Consistency is also evident across other time periods (e.g., one month following incurral, etc.).

Within the HMO, several factors may affect the lag pattern. These include:

- Problems or changes in claims processing procedures and practices
- Significant changes in membership
- Changes in staffing patterns of claims processing personnel
- Changes in utilization patterns due to seasonal fluctuations

It is imperative for each HMO to recognize the uniqueness of its own claims lag pattern and not apply the patterns of other plans in estimating its claims liabilities.

Second, combinations of alternative applications of claims lag factors are possible. For example, one might compare the pattern of claims expenses from one quarter to another and develop a ratio of claims expenses to previous revenue. Liabilities may be forecasted through application of this ratio factor to premium revenue. The most appropriate estimation method is a judgment to be made by each HMO based upon its own circumstances and characteristics. In fact, many larger HMOs use multiple techniques for comparative purposes. The significant point to be made is the need for accurate, comprehensive, and timely claims lag data to permit forecasting.

Once the claims liability accrual has been determined, the appropriate accounting transactions must be performed. Phase 4 of the claims liability management process addresses this issue.

PHASE 4: RECORDING THE LIABILITY

A claims liability accrual is an accounting transaction designed to perform the following functions:

- Allocate to the proper month (that is month of service) the expected expenses for the month
- Permit the matching of revenue and expenses for the same accounting period
- Provide financial statements accurately portraying the HMO's financial position

The claims liability accrual reflects the HMO's best determination of outstanding claims liabilities for a period. As claims are paid for the period, the accrual should be adjusted to reflect those payments. Consequently, the Accrued Claims Liability provision is subject to change and requires monitoring.

(1) The Claims Liability Accrual Should Be Reflected On The HMO's Balance Sheet

To accurately reflect the HMO's true financial position, the claims liability accrual should be present on the HMO's Balance Sheet. This provision is generally known as "Accrual Claims Liability." In those cases when an HMO contracts with an Independent Practice Association (IPA) on a capitation basis, the accrual should appear on the Balance Sheet of the IPA. In any event, one corporation or the other must recognize the liability.

(2) The Accrual Should Be Adjusted Over Time To Reflect Actual Claims Payments

In the example below, a liability accrual of $100,000 is reduced as claims totalling $50,000 are entered into the payables system:

The example below demonstrates this principle:

Estimated Total Claims Expenses =	$100,000
Accrued Claims Liability =	$100,000

Transaction

Credit - Accrued Claims Liability	$100,000
Debit - Medical Expenses	$100,000

Transaction

Debit—Accrued Claims Liability $50,000
Credit—Claims Payable $50,000

When the Balance Sheet is prepared, the Accrued Claims Liability will reflect:

Total Estimated Claims Expenses Minus Claims Paid And Claims Recorded As Claims Payable

Medical expenses may be broken down into multiple accounts such as hospital, referral specialist, primary care physician, etc.

(3) Accruals Should Be Monitored

Constant monitoring is required to determine the adequacy of the accrual. The ongoing pattern of claims payment must be compared to the liability provision to assure consistent and accurate financial records.

* * * * *

The claims liability management system presented in this chapter is based upon a continuous information flow between HMO administrative personnel and providers of health services. The overall effectiveness of the system will be determined by the rigor with which HMOs follow the many procedures and processes comprising the system. The bottom line is the fact that an HMO can not merely wait to learn of its claims liabilities by receiving a claim. Plans must aggressively obtain claims information as early as possible, including before service is provided—when practicable.

APPENDIX A

SAMPLE CLAIMS POLICIES AND PROCEDURES

Policy Or Procedure	Page Number
Claims Processing Procedure	A-1 - A-4
Primary Care Physician Claim Form Submission Policy	A-5 - A-11
Claims Form Submission Policy From Primary Care Physician Provider Manual	A-12 - A-20
Explanation Of Primary Care Physician Remittance Advice	A-21 - A-28
Participating Specialist Referral Procedure	A-29
Non-Participating Specialist Referral Procedure	A-30 - A-31
Referral Procedure	A-32
The Primary Care Referral System	A-33 - A-34
Inpatient Admission Log	A-35

INTRODUCTION TO SAMPLE CLAIMS POLICIES AND PROCEDURES

The policies and procedures contained in this appendix have been drawn from federally-qualified HMOs, and are examples of policies and procedures discussed in Chapter II. They address issues such as:

- The manner in which claim forms are completed
- Time limits for claims submission
- Claims appeal procedures
- Claims processing control activities
- Provider remittance advices
- Referral notification procedures
- Logging inpatient admissions and claims

These policies and procedures should provide HMO managers with alternative approaches to controlling claims processing activities. Each HMO must develop and implement policies and procedures appropriate to its environment. Consequently, these materials should be reviewed as examples and are not presented as the ideal approach for all HMOs.

CLAIMS PROCESSING PROCEDURE

A. OVERVIEW

The purpose of this manual is to present a detailed description of the flow and manual processing stages of claims payment by the Health Plan. Most claims for medical services are sent to the Plan directly by providers (physicians, hospitals, laboratories, etc.). In some instances, most notably Major Option Benefits, claims are submitted by the Plan member for direct reimbursement.

Claims are screened, coded, sorted, and batched with those identified as requiring review being sent to the appropriate individual. Those claims deemed processable are entered into the computer via a Cathode Ray Tube (CRT). During the data entry process, the computer performs several important functions:

- Member eligibility verification
- Provider eligibility verification
- Benefit verification
- Pricing limit verification
- Edits to determine validity of codes

The system includes both interactive (at the time of data entry) and batch processing capabilities. An important on-line function of the system is the retrieval of complete patient and provider profiles. This function, combined with the ability to cross reference members' I.D. numbers via an alphabetic inquiry, is a most powerful tool in researching both problem claims and various inquiries from Plan members or providers of services.

B. CLAIMS PROCESSING PROCEDURE

Step 1 - Mailroom - Claims are forwarded to Sorting/Screening

Step 2 - Sorting/Screening

A. Claims are sorted by type:

1. Encounters - by Specialty Type (e.g., Pediatrics)
2. Referrals - by Specialty Type
3. Inpatient
4. Major Option
5. Laboratory
6. Radiology
7. Hospital Outpatient
8. All Other Claims
9. Out-of-Area
10. Anesthesiology
11. In-Area Emergency

B. Screening is performed to identify claims which require additional information or codes. Information which might be missing includes the following:

1. Provider I.D. No.
2. Member I.D. No.
3. Diagnosis Code
4. Procedure Code
5. Amount Billed
6. Date of Service

C. Batching/Claim Number Assignment is performed after the claims have been screened. After all claims have been sorted and screened, they are batched into groups of 50 and stamped with the CLAIM BATCH STAMP. This stamp provides each claim with the following number:

A B C D
9 250 01 01

A = Last digit of the year, e.g. 1979 = 9

B = Three digit Julian date, e.g., Jan. 1 = 001 Dec. 31 = 365

C = Two digit batch number - assigned sequentially by coder

D = Two digit claim number - assigned sequentially by coder

Once the claims have been assigned a unique claim number, they are placed into Claim Folders. The Claim Folder has been designed to indicate which claims from a particular batch have been pulled for purposes of research and/or correction. In the event a claim must be removed from the folder, the following information is entered on the face of the Claim Folder:

- Date - The date the claim was reviewed.
- Claim No. - The 8 digit claim number.
- Sent To - The person to whom it was sent.
- Reason Sent - Why the claim was pulled.
- Sender - Person pulling the claim.
- Date Returned - Date the claim was returned.

D. Problem claims, those requiring additional information or codes, are routed by batch to the appropriate department. Claims passing the screening process are forwarded by batch to data processing.

The following table indicates the appropriate department to which problem claims are routed:

	CLAIM TYPE	DATA MISSING	SEND TO
1.	Encounters	Member I.D. No.	Data Collection
		Provider I.D. No.	Data Collection
		Diagnosis Code (Hand Written)	Data Collection
		Procedure Code (Hand Written)	Data Collection
		Amount Billed Over $100	Claims
		Nothing Missing	Data Processing
2.	Referrals	All Referrals	Data Collection
3.	Inpatient	All Inpatient Claims	Claims
4.	Major Option	All Major Option Claims	Claims
5.	Laboratory	All Laboratory Claims	Claims
6.	Radiology	All Radiology Claims	Claims
7.	Hospital Outp.	All Hospital Outpatient Claims	Claims
8.	All Other Claims	All Other Claims Claims	Claims

E. Certain claims must be returned to the provider in order to complete the form for processing. Claims missing the following data must be returned:

Missing Data

- Member I.D. No. AND Name
- Procedure (None checked or written)
- Diagnosis (None checked or written)
- Billed Amount
- Date of Service

When mailing these forms to the providers, include the appropriate form letter specifying why the claim is being returned.

F. After all claim forms have been sorted and stamped, the following report is completed by the individual responsible for sorting and screening. (See Attached Report.)

INCOMING CLAIMS - CLAIMS RECEIVED REPORT

WEEK ENDING:

DATE	PRIMARY CARE PHYSICIAN	REFERRALS	INPATIENT	OUT OF AREA	MAJOR OPTION	LABS	RADIOLOGY	ANESTHESIA	HOSPITAL OUTPATIENT	OTHER
WEEKLY TOTALS										
MONTHLY TOTALS										
YEAR TO DATE TOTALS										

STATEMENT OF PROFESSIONAL SERVICES
(CLAIM FORM)

I. INTRODUCTION

The Statement of Professional Services, or claim form, is used to bill the Plan for services provided by physicians and laboratories. Professional services include, but are not limited to, office and hospital visits, consultations, immunizations, surgical procedures, lab tests, X-rays, and medical equipment. A statement is to be filed for each patient of the Plan who is seen by the provider.

Your cooperation in the accurate completion of the claim will help ensure prompt payment of your bill. Missing items and incorrect information only slow down the processing of the claim.

After the Statement of Professional Services has been properly completed, signed, and dated, mail or deliver the white and blue copies (Original and Claim Copy) to the Plan. Retain the yellow copy (Physician's Copy) for your records.

Refer any questions about the claim form to the Claims Department.

II. CLAIMS POLICY

60-Day Cutoff

We urge you to file claims at least monthly. Claims must be submitted within 60 days after the date of service. If not, the claim will be denied and returned to you. Such denied charges are not billable to the patient. If you have a valid reason for late submission of a claim, please indicate the reason on the claim; and we will consider unusual circumstances.

Unpaid Claims

We try to pay all claims within 60 days of receipt. If a claim is unpaid 60 days after filing, the Plan will research the payment status on it only at your request. Send a Xerox copy of the unpaid claim and clearly indicate that the submission is for research on payment status.

If you have any questions, please call Claims Research. We will make every attempt to give you prompt feedback on the status of unpaid claims.

Claims Appeals

If you feel the Plan has unfairly processed or improperly coded a claim which resulted in inequitable reimbursement, you have the option to appeal. For reconsideration of payment, please file the appeal in writing. Address the letter to Provider Services along with a Xerox copy of the original claim. Be sure to include the payment date located in the upper right-hand corner of the Detail of Remittance involving the disputed claim.

III. COMPLETION INSTRUCTIONS

Shaded gray areas are for Plan use only. Do not write in these shaded areas. See sample on page ___.

The new claim form is designed to be used with an imprinter. If you have an imprinter, please use it. This will allow you to leave Items 7, 8, 9, and 10 blank. Imprinters are available to primary care physicians and/or high volume practices. If you do not have an imprinter, every item must be completed.

Item 1 - COPY FROM SUBSCRIBER'S PLAN I.D. CARD (CIRCLE PATIENT)

- If you have an imprinter, use the subscriber's Plan I.D. card. CIRCLE THE NAME OF THE PATIENT.

- If you do not have an imprinter, please enter the group number, I.D. number, and name of subscriber from the Plan I.D. card. Do not enter the name of the patient in this space; patient's name is entered in Item 7.

Item 2 - IF PATIENT WAS REFERRED, INDICATE: FROM DOCTOR

- If you are not a primary care doctor, you must enter the name of the physician making the referral. Enter the first and last name of the doctor who referred the patient to your office. For laboratories and X-ray offices the name of the referring physician is very important.

- If patient was self-referred, enter "None."

Item 3 - PROVIDER IDENTIFICATION

- If you have an imprinter, use the provider's Plan I.D. card.

- If you do not have an imprinter, enter the I.D. number and name of the participating provider. It is very important that the I.D. number and name entered here be exactly as it appears on the provider I.D. card. Your payment is made according to this number. If it is incorrect, the wrong provider will get paid.

- For nonparticipating providers, enter the address also.

Item 4 - DIAGNOSIS AND CONCURRENT CONDITIONS: PRIMARY

- Enter the primary diagnosis. Include only those conditions for which the patient was seen on the date of service.

- The primary diagnosis is the problem that prompted the patient to seek care on the service date.

Item 5 - DIAGNOSIS AND CONCURRENT CONDITIONS: SECONDARY

- Enter the secondary diagnosis if there is one.

- The secondary diagnosis is usually a chronic problem that can affect or influence the management of a primary problem. For example, a diabetic seeking care for a sore throat:

  1. Primary - Pharyngitis.
  2. Secondary - Diabetes Mellitus.

- Sometimes a secondary diagnosis may be the cause of the primary diagnosis. For example, an alcoholic with a gastric hemorrhage:

  1. Primary - Gastric Hemorrhage.
  2. Secondary - Chronic Alcoholism.

Item 6 - ADDRESS OF SUBCRIBER: STREET, CITY, STATE, AND ZIP

- If you used the imprinter in Item 1, leave the item blank unless the patient has changed his address.

- If the imprinter was not used, enter the subscriber's address.

- Check the box if the subscriber has changed addresses.

Item 7 - NAME OF PATIENT: LAST, FIRST, MIDDLE INITIAL

- If you used the imprinter in Item 1 and have circled the patient's name, leave this item blank.

- If the imprinter was not used in Item 1, enter the patient's name.

Item 8 - SEX

- If you used the imprinter in Item 1 and have circled the patient's name, leave this item blank.

- If the imprinter was not used in Item 1:

  1. Enter "F" for female.
  2. Enter "M" for male.

Item 9 - BIRTH DATE

- If you used the imprinter in Item 1 and have circled the patient's name, leave this item blank.

- If the imprinter was not used in Item 1, enter the month, day, and year of birth of the patient.

Item 10- RELATIONSHIP OF PATIENT TO SUBSCRIBER: SELF, SPOUSE, SON, DAUGHTER, OTHER

- If you used the imprinter in Item 1 and have circled the patient's name, leave this item blank.

- If the imprinter was not used in Item 1, then check the appropriate box:

  1. "Self" if the patient is the subscriber.

  2. "Spouse" if the patient is the wife or husband of the subscriber.

  3. "Son" or "Daughter" if the patient is a child of the subscriber.

  4. "Other" if patient is some other relationship to the subscriber. Specify what the relationship is, e.g., a grandchild who is a legal dependent of the subscriber.

Item 11- DATE OF SERVICE

- Enter the month, day, and year the service was rendered.

- For services provided on different days, enter the date of each service.

Item 12- DESCRIBE EACH SERVICE OR APPLIANCE SEPARATELY

- Briefly describe each service or appliance as it is used in the RVS (California Relative Value Studies - 1974 Revision) coding manual. Services include office and hospital visits, consultations, lab tests, X-rays, injections, and surgical procedures. Appliances include medical equipment and prosthetic devices.

- For office visits, please indicate the type and extent of the visit. For example, new vs. follow-up visit; limited, extended, or comprehensive visit. Be sure to document any unusual circumstances surrounding the visit (e.g., evening visit) which might justify a higher rate of payment.

- For immunizations, enter the type of immunization.

- For other injections, enter the name, dosage, and route of administration of the drug.

Item 13- PROCEDURE NUMBER

- The procedure number refers to the RVS which matches the service described in Item 12. The RVS refers to the California Relative Value Studies, 1974 Revision.

- Enter the appropriate RVS code for each service and appliance provided.

- It is important that the procedure number (code) accurately match the description of the service. If you are unsure of the proper code, leave it blank.

Item 14- BILL AMOUNT

- Enter the billed amount for each service or appliance entered in Item 12.

- Be sure to include the tax in each line item.

Item 15- TOTALS

- Enter the total of the Bill Amount column.

Item 16- LOCATION OF SERVICE: HOSPITAL, OFFICE, E.R., HOME

- Check the appropriate box for each service rendered in Item 12. For services or procedures that took place at different locations, such as the office and E.R., you would check both the office and the E.R. boxes.

- Lab and X-ray offices do not need to check any box.

Item 17- LAB SENT TO

- If any laboratory procedures are listed in Item 12, indicate where the tests were done.

  1. If lab work was done in the physician's office, enter the physician's name.

  2. If lab work was sent out to a commercial laboratory, enter the name of the lab. Address is not needed.

  3. If some lab work was done in the doctor's office and some sent out, specify which tests were done in the office and which were sent out of the office.

Item 18- DOES THE PATIENT HAVE ANY OTHER INSURANCE? YES OR NO

- If patient has other health insurance, please check "Yes." Examples of other health insurance include Blue Cross/Blue Shield, Equitable, Medicare, etc.

- Try to ask the patient about other coverage. Many families have duplicate coverage when both the husband and wife are employed and we can coordinate benefits with the other carrier.

- If patient has only Plan coverage, check "No."

Item 19- NAME OF OTHER INSURANCE

- If "Yes" is checked in Item 18, enter the name of the other insurance carrier.

- If "No" is checked in Item 18, leave item blank.

Item 20- DID THIS VISIT RESULT FROM: ILLNESS, INJURY, EMERGENCY, OTHER

- Check the appropriate box. If illness was the reason for the visit, check "Illness," and so on.

Item 21- IF INJURY, PLEASE STATE CAUSE

- If the reason for the visit was injury-related, specify the cause of the injury.

- On all injuries we send the patient an accidental injury form to find out if there is other liability. For example, auto accident, work-related accident.

Item 22- IS THIS ILLNESS OR INJURY A RESULT OF EMPLOYMENT? YES OR NO

- If the illness or injury for which the patient was seen was work related, check "Yes."

- If the reason for the visit was not related to employment, please check "No."

Item 23- I HEREBY CERTIFY THAT THE ABOVE BILL IS CORRECT AND THAT ANY PAYMENTS RECEIVED FROM THE PATIENT OR OTHERS ARE SHOWN ABOVE: SIGNATURE, TITLE, DATE

- Each claim should be signed and dated by the physician and his/her authorized signature. If you, the physician, wish to delegate this responsibility, we will accept such submissions. However, the use of a signature stamp or delegation of your signature in no way relieves you of the responsibility for the accuracy of the claims.

- Specify the title of the certifier.

CLAIMS POLICY

Claim Form—(Report of Service)

Call the Professional Services Department to request an additional supply of Report of Service Forms; allow at least one week for processing. Each form is preprinted with the physician's name, address and provider number; do not use another physician's form.

60 Day Cutoff

Providers are urged to file Reports of Service as soon as possible after service is rendered and at least monthly. Reports of Service must be submitted within 60 days after the date of service or the payment for service will be denied. Such denied charges are not billable to the patient. If a valid reason for late submission of a Report of Service exists, please indicate the reason for late submission on the Report of Service; unusual circumstances will be considered.

Incomplete Reports

The required information requested on the Report of Service is essential to Preferred Care's processing of the service. Submission of incomplete or inaccurate information can result in Preferred Care making erroneous determinations on the service (e.g., denial, reduced payment). Assistance can be received in completing the Report of Service Form by contacting the Professional Services Department.

Notice of Receipt

If the HMO experiences a delay or problem in processing a Report of Service Form, the provider will be notified. The Routine Payment/Explanation of Benefits cycle should provide physicians reasonable notice on the status of submitted services.

Unpaid Claims

The Plan attempts to resolve all services within 30 days of receipt. If a service is unpaid 45 days after filing (and notice has not been received from the Plan) the payment status will be researched at the provider's request. Submit a photocopy of the unpaid Report of Service to Claims Research and clearly indicate that the submission is for research on payment status.

The Plan will make every attempt to give prompt feedback on the status of unpaid services. If there are any questions, please call Claims Research at 999-9999.

Claims Reconsideration

If a provider feels the Plan has improperly or unfairly processed a service which has resulted in denial or inequitable reimbursement, the provider may

request reconsideration. For reconsideration of payment, please contact the Nurse Coordinator or Medical Director. Be sure to identify the claim # from the Explanation of Benefits.

Fee Certification

Participating providers certify their usual and customary fee for common ambulatory procedures (which are not covered by an established schedule in this community) at the time they contract with the IPA and annually during July of each year. The certified fees remain in effect during the Plan's premium year which normally begins in November.

Reimbursement will be based on the fee certified, but will not exceed the 80th percentile fee (maximum fee) for each certified service within each specialty. Physicians whose fee(s) exceeds the maximum fee will be notified of the maximum allowable fee for that service. The maximum fee for specialties with less than five physicians will be established by the Fee Committee.

The maximum fee for each specialty will be based upon the fees submitted by contracting physicians. Individual physician fee changes and fees from new physicians (not available at the time the maximum fee is established) will be included in determining the maximum fee at the next premium determination period.

Payment Amount

The Plan will pay the amount billed, less applicable copayment and risk withholding, unless the amount billed exceeds:

1) The certified fee (up to the specialty maximum)

2) The fee schedule or

3) The reasonable fee determined by review of the Rochester IPA Fee Committee.

By Review (BR)

The IPA Fee Schedule contains a number of procedures for which a specific local fee could not be determined or is infrequently encountered. These procedures are identified in the fee schedule with a unit value of "BR." Processing of services coded BR will be delayed as each claim will require review by the Fee Committee. When the Fee Committee determines a value for a BR procedure, the Fee Schedule will be updated.

Copayments

Plan members are instructed to pay copayments to the provider at the time of service. Collection of copayments is the responsibility of the provider and

claims payment will assume copayment collection. Any provider who has a problem collecting copayments from a member should notify the Professional Services Department. The following copayments must be paid by members:

$ 3.00—	office visit including pre-operative, post-operative, prenatal, and post-natal visits
$10.00—	house calls
$20.00—	emergency room visits
$75.00—	newborn nursery care
$ 3.00—	mental health initial intake/evaluation visit
50% of charge -	other mental health visits

Hospital In-Patient Care

Each day the attending physician provides medical services to a hospitalized member, the Plan will pay the attending physician in accordance with the basic fee schedule. (See Fee Codes 90250 - 90260) Certain inpatient cases require consideration beyond the routine medical service visit allowance.

Payment for intensive hospital medical services will be By Review on an individual case-by-case basis. Intensive hospital medical service claims are covered only when a critically ill patient requires repetitious or prolonged visits for treatment as distinct from diagnosis and observation and unusually long periods of time are spent with a patient who is acutely ill, requiring extensive personal services of the attending physician.

Payment for comprehensive hospital medical services will be By Review on an individual case-by-case basis and are covered only if submitted to and certified by the Hospital Certifying Committee. A comprehensive hospital medical claim:

- Involves a complete history, a complete physical examination and evaluation of laboratory studies done in the hospital
- Includes the consultative services of a medical consultant who assumes care of a referred case
- Is limited to 5 days during a 4 month period
- Is limited to one claim for comprehensive services rendered any time during the hospital stay
- Represents a maximum rather than a set fee payment so that conceivably some cases may qualify for only part of the additional comprehensive claims
- Must be adequately supported with notes in the hospital records

Submit claims for intensive or comprehensive services with the billing for routine in-hospital visits. Intensive or comprehensive claims submitted separately from the routine in-hospital visit billing must be submitted within 60 days of service. Comprehensive claims will be paid after the Plan receives the hospital's certification from the attending physician.

FORMS

This section contains instructions for completing the forms required when rendering services to Plan members. The Plan has made a conscious effort to minimize paperwork and would appreciate suggestions about improving the forms. If any provider has questions about completing Plan forms, please call the Professional Services Department.

Report of Services

The report of Services Form functions as a brief medical report and also a claim for services rendered. When properly completed, the Report of Service will enable the Plan to quickly process claims to resolution without the delays associated with record requests.

The form is designed to include information on all the services associated with a patient visit. Multiple services or visits (occurring over a brief period of time—1 to 2 weeks), may be included on one form, but the Plan must receive the form as soon as possible after the service is rendered. When the treatment plan for a patient involves multiple visits over a moderate or long period of time, submit the Report of Service Form for the first visit immediately and specify the duration of treatment in the follow-up section.

The Report of Services is a specialty specific form. Providers who have contracted to participate in more than one specialty should be certain that the form submitted identifies the specialty of practice for the services rendered.

Diagnosis coding assistance follows at the end of this section. The Plan uses the International Classification of Disease, 9th edition, Clinical Modification (ICD-9-CM) system to code diagnosis.

Precertification Form

The Precertification Form functions as a referral form and request for Plan certification. The provider calls the Professional Services Department to have the form completed by the Plan. If a provider wishes to complete the form and mail to the Plan, contact the Professional Services Department for a supply of forms.

Report of Services
Instructions:

1) Subscriber Data: Imprint this block with the member's Identification Care or complete the following information:

a. Identification Number—The subscriber's nine digit I.D. number (the subscriber's Social Security number). All members on a family contract are referenced by the I.D. number of the family.

b. Subscriber Name—Complete only if the patient is not the subscriber.

2) Patient Data:

a. Patient Name—Full last, first name, and middle initial.

b. Sex—M for male, F for female.

c. Date of Birth—Month/Day/Year of patient's birth.

d. NF/WC*—Check appropriate block if related to auto accident or other on-the-job injury, or leave blank.

e. Other Insurance*—Check Yes or No; if Yes, indicate the name of the other health carrier.

*NOTE: The payment or processing status of the claim will not be affected if the patient has other coverage, however, the Plan will seek reimbursement from the other carrier, when appropriate.

3) Place of Service: Check the appropriate block where the service was rendered. When checking the "Other" block, briefly identify the place of service. If multiple locations of service are involved for several services, indicate the place of service for each service in item #14 - Billing Description.

4) Category of Visit: Check the block which most appropriately describes the major reason for the visit, service, or procedure. When checking the "Other" block, briefly describe the reason.

5) Referring Physician: To be completed only by providers who are not the patient's designated Primary Care Physician or who are not providing coverage for the patient's Primary Care Physician. Indicate the name of the physician who referred the patient; in most cases, this should be the patient's designated Primary Care Physician.

6) Coverage for Physician: To be completed only by providers who have rendered service to another Plan Physician's patient while providing after-hours or weekend coverage. List the name of patient's regular physician for whom you are covering.

7) Medical Problems: To be completed when;

a. Unusual or complicated circumstances are involved in the case.

b. The diagnosis coding and other information submitted does not adequately explain the case.

c. Symptoms presented by patient are not reflected in the diagnosis.

d. Frequent or unusual services are rendered.

Include sufficient description to assist the Peer Review Committee in reviewing the services rendered.

8) Outpatient Lab: Check Yes or No; if Yes, then check one of the place blocks. When checking the "Other" place block, identify the place the lab procedure will be done and briefly indicate the reason the contracted Lab was not used.

9) Outpatient X-ray: Check Yes or No; if Yes, then identify the name of the provider who will perform the procedure. (Must be a Plan participating provider; e.g., a Plan radiologist).

10) Outpatient Prescriptions: Check Yes or No; if Yes, then indicate the number of prescriptions written for each general category listed. Although the Plan is not initially offering a direct Rx program, there is Rx coverage under the Plan's Plus option and this information will be necessary to process these claims. Additionally, this information will be used to make actuarial projections when the Plan develops a direct Rx program.

11) Diagnosis - Use ICD-9-CM: A reference list of common diagnoses follows the sample report of services. Use the diagnosis that most appropriately describes the patient's condition. If the appropriate diagnosis is not on the reference list, please refer to the full ICD-9-CM.

a. Major Diagnosis - Indicate the Dx code and a brief description for the major diagnosis related to the services rendered.

b. Other Diagnosis - Indicate the Dx code and a brief description for up to two other diagnoses.

12) Date of Service: Indicate the Month/Day/Year for each service rendered. For in-hospital services, indicate the inclusive dates for each type of visit and indicate in the description the number of visits.

Example: If the physician visits a patient in the hospital on 10/01, 10/02, 10/03, 10/05, 10/06, 10/08, 10/10, and 10/12, the billing information would be as follows:

Date of Service	RVS Code	Description
10/01/79	90250	1 visit
10/02 - 10/06	90251	4 visits
10/08 - 10/12	90252	3 visits

NOTE: If more than four services are being billed, attach a second form. Complete only the ID Number, Patient Name, Billing Information, and Provider Information sections on the second form. Please submit bills as soon as possible after the service is rendered.

13) RVS Code: Indicate the specific RVS code applicable, after each date of service, that most closely describes the service rendered. If the service

rendered is included in the menu of common codes, please circle. If the service is not included on the pre-printed form, refer to the fee schedule section of the Handbook for Providers.

14) Description: Briefly describe the service rendered, if the code is not circled on the form. Also include any explanation or comments necessary to clarify the service rendered, such as the number of visits for in-hospital services.

15) Amount Billed: Enter the amount certified when contracting with the IPA, fee schedule amount, or usual and customary, if the service was not certified or is not included in the fee schedule.

16) Total Billed: Sum the services being billed; if a second page was required, place grand total on the first page.

17) Risk Amount: Calculate the risk amount withheld by multiplying the total amount billed by the percentage factor and enter on form. This can be left blank and will be calculated by the Plan.

18) Copayment Amount: Enter the applicable copayment amount for the visit. If more than one ambulatory visit is involved, be sure to include all applicable copayments. This can be left blank and will be entered by Preferred Care.

19) Amount Initially Due: Subtract the risk withholding and copayment amounts from the total billed and enter the balance due. This can be left blank and will be entered by the Plan.

20) Provider Information: Preferred Care will preprint this block for each provider and furnish a supply of forms. If a provider has contracted for more than one specialty (e.g., Internal Medicine and Hematology), a separate supply of forms will be furnished for each specialty with a different provider number. Be sure to use the correct form corresponding to the specialty for the service provided.

21) Patient Management Plans: Indicate, when appropriate, the plans for completing the course of treatment.

22) Follow-up Plans: Indicate, when appropriate, follow-up care that is required for the patient.

NOTE: Specialty referrals, major diagnostic testing, and non-emergency hospital admissions require precertification. Refer to precertification section in the Handbook for Providers for specific details.

23) Signature: Sign and date.

Precertification Form—Page 8.10
Instructions:

1) Subscriber Data: Imprint this block with the member's Preferred Care Identification Card or complete the following information:

a. Identification Number—The subscriber's nine digit I.D. number (the subcriber's Social Security number). All members on a family contract are referenced by the I.D. number of the family.

b. Subscriber Name—Complete only if the patient is not the Subscriber.

NOTE: This information should be the same as on the Report of Services for the visit that coincides with the precertification request.

2) Patient Data:

a. Patient Name—Full last, first name, and middle initial.

b. Sex—M for male, F for female.

c. Date of Birth—Month/Day/Year of patient's birth.

d. NF/WC—Check appropriate block if related to auto accident or other on-the-job injury, or leave blank.

e. Other Insurance—Check Yes or No; if Yes, indicate the name of the other health carrier.

NOTE: This information should be the same as on the Report of Services for the visit that coincides with the precertification request.

3) Place of Service: Check the appropriate block where the service will be rendered. When checking the "Other" block, briefly identify the place of service. If multiple locations of service are involved for several services by the same provider, indicate the place of service for each service in item number 6 - Referral For:

4) Category of Illness: Check the block which most appropriately describes the major reason for the service to be precertified.

NOTE: This information should be the same as on the Report of Services for the visit that coincides with the precertification request.

5) Request For:

Hospital Admission - Indicate the name of the hospital where patient will be admitted.

Est. L.O.S. - Indicate the physician's estimate for the patient's length of stay.

Admission Date - Indicate the estimated date of admission.

6) Referral To: Indicate the name of Provider who will render service. Check one or more of the following categories:

For Consultation/Evaluation - Services rendered by a Specialist whose opinion or advice is requested in the evaluation of a patient's illness or problem.

For Follow-up Treatment - Services rendered by a Specialist who has assumed responsibility for the treatment of a patient's diagnosed illness or problem, including surgical care.

For Special Tests/Procedures - Special diagnostic or therapeutic testing or procedures requiring precertification (see Referral Policy Section).

Ambulatory Surgery - Out-patient surgical procedures occurring at the time of initial specialist visit or when authorization is for ambulatory surgery only.

7) Reason for Request: Include appropriate clinical information to assist the Peer Review Committee in reviewing the requested service or procedure.

8) Requested By: Name of requesting Physician and date of request.

9) Diagnosis - Use ICD-9-CM: A reference list of common diagnoses follows at the end of this section. Use the diagnosis that most appropriately describes the patient's condition. If the appropriate diagnosis is not on the reference list, please refer to the full ICD-9-CM.

a. Major Diagnosis - Indicate the Dx code and a brief description for the major diagnosis related to the referral.

b. Other Diagnosis - Indicate the Dx code and a brief description for up to two other diagnoses.

NOTE: This information should be the same as on the Report of Services for the visit that coincides with the precertification request.

10) Preferred Care Office Use. Do not complete.

DETAIL OF REMITTANCE (DOR)

I. INTRODUCTION

The Detail of Remittance (DOR) is your computer copy showing the claims processed since the last payment period. It provides you with a detailed breakdown of your payment for each service provided.

If you have any problems interpreting the DOR, call the Claims Department.

II. EXPLANATION OF DOR

The DOR may seem complex, but you need not be concerned with all the information it contains. The three important areas for you to become familiar with are:

1. Payment summary - at the end of the DOR.
2. Claim information - especially the patient's name and I.D. number, service date, charged and paid amounts, and explanation codes.
3. Codes - the three types and what they mean.

An explanation of these areas follows. An example of a DOR for your reference is on page ___.

A. Payment Summary

When you receive your DOR, look first to the summary information on the last page. The "TOTAL CHARGES" is the total amount you billed us for the claims included in this detail. The "TOTAL PAID" is the amount we paid you for those claims.

Any charges that were denied or reduced are included in the "O.M.A." or "BILLABLE TO MEMBER" figures. Two types of codes explain why a particular charge was denied or reduced. The back of every claim form contains an explanation of these "A-codes" and "numerical codes." See page ___.

The following is an explanation of the summary items:

NO. OF CLAIMS: - Total number of claims included in this DOR.

TOTAL CHARGES: - Total amount you billed us for the claims in this DOR. It is the total of the "TOT CHARGED" column.

O.M.A.: (Never Billable to Patient) - Amount of the "TOTAL CHARGES" that exceeds our established ceiling or is denied by peer review. It is the total of all "O.M.A." charges. To find the reason a particular charge was cut or denied, you must refer to the A-codes found in the body of the DOR under the column heading "ADJ." See the "Explanation of Codes" section for details.

BILLABLE TO MEMBER: - Amount of "TOTAL CHARGES" that is ineligible for reimbursement from the Plan. It is the total of the "INEG AMOUNT" column. Numerical codes under the "CD" column in the body of the DOR indicate the reasons for ineligibility. See the "Explanation of Codes" section for details. These charges are billable to the Plan member.

ELIGIBLE: - Amount which determines the eligible amount the Plan can pay you. It is the total of the eligible charges ("ELIG AMOUNT" column). For example, if our reimbursement rate is 90%, the Plan pays you 90% of the eligible amount.

TOTAL CONTRACTUAL ALLOWANCE: - Amount of the "ELIGIBLE" that the Plan withholds from your payment, e.g., 10%. It is also the total of the "TOT CNTR ALLOW" column.

TOTAL PAID: - Total amount payable to you. The paid amount is determined by the reimbursement rate, e.g., 90% of the "ELIGIBLE" amount. You can also compute this by adding the "AMOUNT PAID" figures (with "***" next to them) for the claim totals in the body of the DOR. The check you receive with the DOR should equal this amount.

PROVIDER: - The I.D. number assigned to you by the Plan. Use this number to identify the physician or office if you call us.

ADJUSTMENTS: - Includes adjustments in your bill made for previous over-payments.

You may find the following equations helpful in understanding how your total payment is derived.

1. ELIGIBLE = TOTAL CHARGES - O.M.A. - BILLABLE TO MEMBER

   From the example of the DOR on page ___.
   $1,238.00 = $1,506.00 - $241.00 - $27.00

2. TOTAL PAID = ELIGIBLE - TOT CONTRACTUAL ALLOWANCE

   From example of the DOR on page ___.
   $1,040.56 = $1,238.00 - $197.44

B. Claim Information

If you have a question regarding the amount we paid you on a particular claim, refer to the body of the DOR. Find the patient's name and I.D. number and the date of service in order to properly identify the claim. The patient's name is in the far left-hand corner of the DOR; the patient I.D. number is just to the right and slightly above the patient's name. The service date is indicated by the column heading "FROM-SERVICE-THRU."

When you correspond with us about a claim, we need 4 items in order to help you:

1. Patient's name
2. Patient's I.D. number
3. Date of service
4. Provider I.D. number and name

Three types of codes explain actions taken on a claim for charges that are ineligible, exceed our ceiling, are denied or reduced by professional review, etc. The 3 types of codes are:

1. A-codes
2. Numerical codes
3. Procedure codes (1974 California RVS)

See the next section, "Explanation of Codes," for further information.

The column headings at the top of each page identify information for each billed procedure on the claim. For each claim, a total is shown for the "TOT CHARGED" and "AMOUNT PAID" amounts. This entry is easy to identify, beginning with "**CLAIM TOTAL**" and ending with "***" next to the "AMOUNT PAID."

The following is an explanation of these column headings which are of concern to you:

PATIENT NAME:	- Name of the patient who received services.
CONTRACT I.D.:	- Subscriber I.D. number.
FROM-SERVICE-THRU:	- The beginning and ending date of treatment.
ADJ:	- Two-digit A-code indicating the reason your "TOT CHARGED" (billed charge) was reduced, denied or approved. For further clarification, see "Explanation of Codes" section.
TOT CHARGED:	- The amount you billed us for the service rendered to the patient.

O.M.A.: - Amount of the "TOT CHARGED" (billed charge) that exceeds our established ceiling or is denied by peer review. If a charge was reduced, denied or approved, the A-code to the left of the charge will explain the reason. For example, an "AO" code indicates that a charge has been reduced to our allowable ceiling. For further details, see "Explanation of Codes" section.

INEG AMOUNT: - The amount of the "TOT CHARGED" that is not eligible for reimbursement. The 2-digit numerical code just to the right of this explains the ineligible amount.

CD: - Two digit numerical code indicating the reason for the "INEG AMOUNT." These are usually noncovered and ineligible charges billable to the patient. See the next section, "Explanation of Codes," for more details.

ELIG AMOUNT: - Amount which is determined to be the allowable and reasonable charge for the service as coded according to the RVS code reflected in the last column of the DOR. The RVS (1974 California Relative Value Studies) code is the numerical procedure code (or "SERVICE I.D.") and is explained in the next section, "Explanation of Codes."

TOT CNTR ALLOW: - Refers to the Total Contractual Allowance, and is the "ELIG AMOUNT" less the "AMOUNT PAID."

AMOUNT PAID: - Amount we paid you for the service provided. It is the "ELIG AMOUNT" less the "TOT CNTR ALLOW." It is a percentage (e.g., 90%) of the "ELIG AMOUNT," or the Plan's reimbursement rate.

SERVICE I.D.: - Numerical procedure code corresponding to the service performed. It is the 1974 California Relative Value Studies code. See next section, "Explanation of Codes," for details.

C. Explanation of Codes

The 3 types of codes indicate the reason a charge might be reduced, denied, or approved. Any action taken on a claim will be accompanied by the appropriate code. An explanation of the A-code and the numerical codes are listed on the back of every claim form. See page ___. Please refer to the claim or this section first for an explanation of the codes. If you still have questions about these codes, call our office.

1. A-Codes

These codes are found in the column heading "ADJ" in the body of the DOR, just to the left of the "TOT CHARGED" and "O.M.A." column. If a charge was reduced or denied, the "O.M.A." shows the amount. Any claims that go through professional review are assigned A-codes whether or not the charges are cut. If a claim was reviewed and approved, the "O.M.A." figures would show ".00." Charges denied or reduced by professional review are not billable to the patient. Please call Provider Services if you have questions about these codes.

The following is an explanation of the A-codes:

A0 - REDUCED - OVER MAXIMUM ALLOWABLE CEILING

A1 - DENIED OR REDUCED BY ESTABLISHED WRITTEN MEDICAL POLICY

A2 - DENIED - OVER 60 DAYS

A3 - DENIED - NO APPROVED REFERRAL

A4 - DENIED - UNAUTHORIZED HOSPITAL ADMISSION

A5 - REVIEWED AND APPROVED BY QUALITY ASSURANCE

A6 - REVIEWED AND DENIED OR REDUCED BY QUALITY ASSURANCE

A7 - REVIEWED AND APPROVED BY PEER REVIEW OR MEDICAL DIRECTOR

A8 - REVIEWED AND DENIED OR REDUCED BY PEER REVIEW OR MEDICAL DIRECTOR

A9 - APPEALED, INVESTIGATED, AND APPROVED

B2 - DUPLICATE CLAIM

2. Numerical Codes

These codes are found in the column heading "CD" just to the right of the "INEG AMOUNT" and "INTERIM ALLOW" column. Any ineligible or noncovered charges are shown as the "INEG AMOUNT." The code indicates the reason for ineligibility. These charges are always billable to the patient.

The following is an explanation of the numerical codes:

01 - TERMINATED MEMBER

02 - SERVICES PROVIDED PRIOR TO EFFECTIVE DATE OF CONTRACT

04 - PATIENT INELIGIBLE ON DATE OF SERVICE

05 - COORDINATION OF BENEFITS

06 - SUBROGATION

07 - WORKMEN'S COMPENSATION

08 - MEDICARE (BILL MEDICARE FIRST AND BILL REMAINDER TO MASTERCARE)

10 - ADMISSION DEDUCTIBLE

12 - MATERNITY DEDUCTIBLE

14 - EMERGENCY ROOM COPAYMENT

16 - OUT-OF-AREA 20% COPAYMENT

17 - NONCOVERED OUT-OF-AREA CHARGE

21 - NONCOVERED BENEFIT

22 - NON PAR REFERRING PHYSICIAN

23 - NON PAR PROVIDER, NO REFERRAL

24 - ROUTINE DENTAL CARE IS NOT A COVERED BENEFIT

26 - HEARING AIDS AND THE FITTING THEREOF IS NOT A COVERED BENEFIT

28 - EYEGLASSES AND/OR CONTACT LENSES AND THE FITTING OF SAME ARE NOT A COVERED BENEFIT

30 - PROVIDED FOR COSMETIC PURPOSES AND NOT MEDICALLY INDICATED

57 - PSYCHIATRIC BENEFITS EXHAUSTED FOR CONTRACT YEAR

60 - PERSONAL ITEMS WHICH ARE NOT MEDICAL IN NATURE ARE NOT A BENEFIT. EXAMPLE: TELEVISION, TELEPHONE, GUEST TRAYS, GUEST COT, ETC.

62 - PRIVATE ROOM NOT MEDICALLY INDICATED

3. Procedure Codes (1974 California Relative Value Studies Codes)

This 5 digit numerical code is found in the last column heading "SERVICE I.D." It refers to the RVS code on the claim form that is assigned by your office or by the Plan for the service provided. RVS is the California Relative Value Studies. For example, 90050 indicates a limited office visit for an established patient.

The procedure (RVS) code is very important. It determines the eligible charge and, therefore, the amount we pay you. If you feel Mastercare has unfairly processed or improperly coded a claim which resulted in inequitable reimbursement, you have the option to appeal. For details on the appeals process, refer to "Claims Policy" on page 1.

PARTICIPATING SPECIALIST REFERRAL PROCEDURE

Attached is the outline of the new primary care referral system recently sent to all primary care physicians and a sample form which the member will fill out at his primary care physician's office. Please review this carefully and have your office personnel become familiar with the following:

1. Established patients currently under your care.

It is the responsibility of the Plan member to inform his/her primary care physician of the need for any continued specialty care. If a Plan member has not informed his primary care physician of ongoing treatment, we will deny the care as billable to the patient. You may continue to treat established patients, but please remind them to discuss the treatment with their primary care physician. You must identify the member's primary care physician as the referring physician on your claim form.

2. New patients referred by a primary care physician.

This patient will be referred directly to you as a participating physician without the necessity of precertification through the Plan office. The patient will be told to make the appointment with your office or the appointment may be made by the primary care doctor's office. When you submit your claim for services rendered, please indicate on the form the name of the referring primary care doctor. If there is a question regarding the direct referral, confirm it with the primary care doctor's office.

3. You cannot refer patients either to nonparticipating physicians or to other participating specialists.

For example—an orthopedist to a cardiologist or endocrinologist or an orthopedist to a rheumatologist. If you feel a patient should see another specialist, you must consult with the referring primary care physician. Necessary laboratory work and X-ray examination may be done on the referred patient, but please be sure that these are not duplication of tests already performed.

4. No claims will be accepted from a participating specialty physician unless you identify the member's primary care doctor as the referring physician on the claim form.

NON-PARTICIPATING SPECIALIST REFERRAL PROCEDURE

Effective immediately you will be paid directly by the Plan for authorized treatment rendered to Plan members. Please follow the following procedure guidelines. Your cooperation is appreciated.

I. Elective Referrals and Consultation

You must have received prior written approval from the Plan. Such referrals will be authorized in the format shown on the attached referral form. Please do not make appointments for referral patients before receiving this form. The Plan subscribers also understand this and know they may be financially responsible for seeing an out-of-plan physician for nonemergency care without prior written referral.

II. Emergency Care—Inhospital or Outpatient

Prior written approval will not be required under these circumstances. Inhospital consultation and care will also not require prior written approval.

III. Elective Hospitalization

Prior approval to admit a Plan patient for elective care (surgical and nonsurgical, inpatient or outpatient surgery) must be obtained by using the hospital admission request form. A prior approval for office care (see I above) does not authorize hospital admission. The primary care physician who initiated the original referral should be made aware of your opinion and if you wish to admit or perform surgery, you must receive prior Plan authorization.

IV. Emergency Hospitalization

If you admit a Plan patient to the hospital under emergency or urgent circumstances, written approval will not be necessary. However, the admission and length of stay will be subject to ongoing utilization review and retrospective professional review just as applies to all hospital admissions.

V. Billing Procedures

Please bill the Plan on our claim form indicating diagnosis, code, etc., and be sure to indicate the name of the referring Plan physician. Please indicate also the nature of the care rendered—elective, emergency, etc. If you bill the Plan directly without the information on the billing form, processing will be delayed and payment of your fee will be unnecessarily delayed. Do not bill the patient. When a Plan patient receives a bill, he discards it thinking that we have been billed. If the subscriber sends the bill to us, we will have to call you and instruct you to bill us on our claim form in order to collect the necessary medical data. Billing us directly on the proper claim form will speed payment.

VI. Reimbursement

You will be reimbursed your billed charges. If billed charges are in excess of the usual, customary, and prevailing rate charged in the medical community by peers for a given service, the Plan reserves the right of appeal.

REFERRAL PROCEDURE

1. A referral form should be completed for:

    1. Referral to Outside Physician
    2. Follow-up Visits
    3. Surgery Authorization
    4. Emergency Room Visits
    5. Ordering serum from allergists

2. Nurse may fill out referral; however, HMO Physician should review and sign every referral. The nurse should not automatically issue any referrals other than emergency room referrals. On these (E. R. referrals made from on-call requests) the doctor's name may be signed with initials of originator.

3. Please indicate number of visits authorized. Complete history and problem as completely and detailed as possible, including any tests or treatments already performed. Also be sure co-payment column is marked when applicable.

4. When consultation report is returned by referral physician—it first goes to Claims for processing. The report then goes to Medical Records where the patient's chart is pulled and is directed to provider who originated the referral.

5. At this time the report should be reviewed to determine whether or not another visit is requested by referral physician. If so, prepare a referral for a follow-up visit and give chart, report, and new referral to doctor for his signature (on received report (initials) and new referral).

6. After physician's review, place report in proper order in chart and give chart and new referral for submission at referral review to Beth Glover.

7. No referrals are to be made to any person or institution with whom we do not have a contract unless authorized by the medical director.

8. Remind patients to notify HMOBR of follow-up appointments BEFORE they go so that authorization may be made (and reviewed).

THE PRIMARY CARE REFERRAL SYSTEM

All subscribers will designate a Primary Care Physician and he/she will be responsible for all referrals within the Plan. The subscribers have been informed of this fact and will be required to seek care within this system. The following are guidelines for referrals.

1. DESIGNATION OF PRIMARY CARE PHYSICIAN BY THE MEMBER

Each member will be completing a primary care form (3-part form) that will be available in the primary care physician's office. The patient will also indicate on this form other nonprimary care physicians they have seen in the past two years. The primary care physician should indicate in the designated area of this form his approval for continued care, if needed, by the other physicians. This will serve as a formal referral for the next 12 months. Distribute the form as follows:

a. Mail one copy to the Plan (white copy)

b. Give the patient one copy (blue copy)

c. Keep the "Physician" copy in the patient's medical chart (green copy)

2. REFERRAL TO PARTICIPATING SPECIALISTS WITHIN THE PLAN

Please refer to the participating provider list to verify participating physicians eligible for referrals from you.

a. Within the Plan, referral may be made directly by the primary care physician. If consultation is needed, have the patient make an appointment directly with this physician. The specialist must indicate on the Plan claim form the name of the referring primary care physician. The subscriber may not see a Plan specialty physician without the knowledge and direction of his primary care physician.

3. REFERRAL TO NONPARTICIPATING SPECIALISTS

The following specialties are not currently participating in the Plan:

Gastroenterology
Cardiology
ENT
Endocrinology
Urology
Nephrology
Podiatry
UNM Cancer Research Center
Others

Referral to a physician in these areas must have prior approval from the Plan except in emergency situations. Have your office call Provider Services to request the out-of-plan referral. These requests will be promptly reviewed by the Medical Director for approval and confirming copies of the approval or denial will be mailed to you (the primary care physician). Please be prepared to give the Plan staff:

a. Diagnosis

b. Scope of services needed

c. Any other pertinent medical data needed

It is of utmost importance that the primary care physician choose the in-Plan and out-of-Plan consultant with thoughtful care--one who can provide quality care in a cost-effective manner. The Medical Director and professional staff at the Plan can be of assistance if requested (see attached list).

4. EMERGENCY REFERRALS

For emergency referrals such as in-hospital and emergency room situations and in certain office situations, the patient will be instructed to:

a. Call the primary care physician

b. If life threatening, go to the Emergency Room at the Plan's participating hospital

c. Report the emergency episode to you as their primary care physician so that you are aware of their overall patient care

5. If a nonprimary care physician specialist sees a patient on referral, he may not further refer the patient to another specialist without the knowledge and consent of the primary care physician.

READEX FICHE

INPATIENT ADMISSION LOG

MEMBER NAME	ID NUMBER	AUTHORIZING PHYSICIAN	ATTENDING PHYSICIAN	INSTITUTION/ HOSPITAL	SERVICE	EMERGENCY/ ELECTIVE	EXPECTED LENGTH OF STAY	ADMISSION DATE	DISCHARGE DATE	ACTUAL LENGTH OF STAY	CHARGES	AMOUNT PAID	DATE PAID	CHECK NUMBER

PRIMARY CARE CLAIM FORMS BY PROVIDER TYPE

APPENDIX B

SAMPLE CLAIMS AND SERVICE NOTIFICATION FORMS

Claim Form	Page Number
Generalized Primary Care Claim Forms	
General Services Encounter Form With Pre-Printed Codes	B-1 - B-2
Physician Service Statement	B-3
Primary Care Claim Forms By Provider Type	
General Medicine	B-4 - B-5
Family Practice	B-6
Internal Medicine	B-7
Internal Medicine	B-8
Obstetrics And Gynecology	B-9
Obstetrics And Gynecology	B-10
Pediatrics	B-11
Laboratory	B-12
Referral Notification And Claim Forms	
Referral Authorization	B-13
Referral Authorization	B-14
Inpatient Admission Notifications	
Authorization For Hospitalization	B-15
Admission Authorization	B-16
Hospital Admission Certification	B-17
Request For Extension Of Certification	B-18
Combined Referral And Inpatient Notification Form	
Referral Form	B-19

INTRODUCTION TO SAMPLE CLAIMS AND SERVICE NOTIFICATION FORMS

The claims and service notification forms contained in this appendix have been collected from federally-qualified HMOs. These forms represent alternative approaches to forms design for primary care physician claims, as well as authorizations for referral specialists' and inpatient services.

These forms demonstrate alternative approaches to issues discussed in Chapter II, such as:

- Single forms for all primary care providers
- Separate forms for each primary care provider type, e.g., internal medicine, pediatrics, obstetrics/gynecology
- Pre-coded diagnosis and/or procedure codes
- Using plastic member I.D. cards for imprinting patient identification information

These forms are presented as examples of alternative forms design and are not considered ideal for all HMOs. Each HMO must determine the best forms design in view of factors such as:

- The HMO's management information system
- Purpose and use of claim forms
- Cooperation and interests of participating physicians

GENERAL SERVICES ENCOUNTER FORM

PROVIDER NUMBER	AUDIT NUMBER
PROVIDER NAME	PRIMARY PHYSICIAN

IF PATIENT HAS INSURANCE COVERAGE, PLEASE OBTAIN THE FOLLOWING INSURANCE INFORMATION:

☐ BLUE CROSS ☐ BLUE SHIELD ☐ OTHER INS. ☐ MEDICAID ☐ MEDICARE ☐ WORKMAN COMP. ☐ NO FAULT

DATE OF SERVICE FROM — — (MO) (DAY) (YR) TO — — (MO) (DAY) (YR)

For Referrals to Participating Physicians Only — Patient's Primary Physician, if other than yourself: _____

Referred To: _____

Primary Physician Concurrence on Referral ☐ Yes ☐ No

#	SERVICE OR PROCEDURE	CPT CODE	USUAL FEE
	NEW PATIENT		
	Brief O.V.	90000	
	Limited O.V. (Routine)	90010	
	Comprehensive O.V.	90020	
	ESTABLISHED PATIENT		
	Brief O.V.	90040	
	Limited O.V. (Routine)	90050	
	Comprehensive O.V.	90060	
	INITIAL HOSPITAL CARE		
	Brief	90200	
	Intermediate	90215	
	Comprehensive	90220	
	SUBSEQUENT HOSPITAL CARE		
	Brief	90240	
	Intermediate	90260	
	Comprehensive	90280	

#	SERVICE OR PROCEDURE	CPT CODE	USUAL FEE
	HOME VISIT		
	Brief	90140	
	INITIAL SKILLED NURSING CARE		
	Brief	90300	
	EMERGENCY ROOM VISIT		
	Brief	90540	
	OFFICE CONSULTATION		
	Limited	90600	
	Intermediate	90605	
	Comprehensive	90620	
	HOSPITAL CONSULTATION		
	Limited	90640	
	Intermediate	90650	
	Comprehensive	90660	

#	TESTS AND X-RAYS ORDERED FROM OUTSIDE FACILITY (LIST)

OTHER PROCEDURES	CPT CODE	USUAL FEE
Specimen of _____ Sent To Outside Lab	99000	

PLACE OF SERVICE			
	1 Doctor's Office		6 Out Patient Hospital
	2 Patient's Home		7
	3 Independ. Lab		8 ER Room
	4 Inpatient Hospital		9 Other Location
	5 Skilled Nursing Facility		

CONDITION DUE TO:	X	DATE		
Injury — Auto				
Injury — Covered by Workman's Comp.				
Illness — Treated Before				
Illness — First Symptoms				

IS THE PATIENT TOTALLY DISABLED?
☐ YES ☐ NO

From / / Thru / /

DISPOSITION:

OF ENCOUNTERS _____

NO. OF CO-PAYS _____

TYPE OF CO-PAYMENT _____

1. OFFICE VISIT
2. HOME VISIT
3. MENTAL HEALTH

TOTAL SERVICES $

CO-PAYMENTS COLLECTED

PATIENT IS STILL UNDER MY CARE
☐ YES ☐ NO

INSTRUCTIONS FOR FILING:

A. FOR PHYSICIAN ENCOUNTERS
1. Forward white & green copies to IHA.
2. Retain blue copy for your file.
3. Dispose of remaining copies.

B. FOR PATIENT REFERRALS TO OTHER PARTICIPATING PHYSICIAN
1. Send white copies to IHA.
2. Give green half sheet to patient.
3. Retain blue copy for your file.
4. Send yellow copy to consultant.
5. Send pink copy to patient's primary physician, if other than yourself.

_____
PHYSICIAN'S SIGNATURE

B-1

Form No. 500 1179

PLEASE CIRCLE DIAGNOSIS ON REVERSE SIDE

PLEASE CIRCLE APPROPRIATE DIAGNOSIS. IF DIAGNOSIS IS NOT LISTED, PLEASE CONSULT YOUR ICD-9-CM VOLUMES AND LIST CODE AND DIAGNOSIS IN SPACE PROVIDED AFTER "OTHER" BELOW. IF THERE IS BOTH A PRIMARY AND A SECONDARY DIAGNOSIS, PLEASE DESIGNATE THE PRIMARY DIAGNOSIS AS "1" AND THE SECONDARY DIAGNOSIS AS "2".

ICD-9-CM LISTING

632 Abortion, missed
643.9 Abortion, spontaneous
640.0 Abortion, threatened
706.1 Acne Vulgaris
255.4 Adrenal cortical hyperfunction
255.5 Adrenal cortical hypofunction
288.0 Agranulocytosis
291.9 Alcoholic psychosis
303.9 Alcoholism
V14 Allergy to Medical Agents
V15 Allergy, Other
277.3 Amyloidosis
284.9 Anemia, aplastic
280.1 Anemia (iron deficiency)
281.0 Anemia, pernicious
648.2 Anemia of pregnancy
285.9 Anemia, unspecified
995.1 Angioneurotic edema
413 Angina pectoris
101 Angina (Vincent's)
783.0 Anorexia
300.00 Anxiety neurosis
540 Appendicitis, acute
541 Appendicitis, unqualified
528.2 Apthous ulcerations, oral
440 Arteriosclerosis
437.0 Arteriosclerosis, cerebral
440.9 Arteriosclerosis, generalized & unspecified
711 Arthritis, acute nonpyogenic
711.0 Arthritis, acute due to pyogenic organisms
714 Arthritis, rheumatoid and allied conditions
716.9 Arthritis, unspecified
493 Asthma
427.32 Atrial fibrillation or flutter
724.9 Backache NOS
V71.02 Behavioral disorders of childhood
626.6 Bleeding, intermenstrual
627.1 Bleeding, postmenopausal
373.00 Blepharitis
680 Boil and carbuncle
494 Bronchiectasis
466.0 Bronchitis, acute
491 COPD
485 Bronchopneumonia, unspecified
727.1 Bunion
427.5 Cardiac arrest NOS
306.2 Cardiovascular disorder of psychogenic origin
366.9 Cataract
681.00 Cellulitis of finger
682 Cellulitis and abscess, other
431 Cerebral hemorrhage
435.9 Cerebral ischemia, transient
434.0 Cerebral thrombosis (CVA)
052.9 Chickenpox (varicella)
780.0 Coma and stupor
850.9 Concussion
372.30 Conjunctivitis and ophthalmia
692.3 Contact dermatitis due to drug
V25 Contraceptive Management
780.3 Convulsions
700 Corns and callosities
277.00 Cystic fibrosis
798.1 Death, sudden (cause unknown)
707.0 Decubitus ulcer
780.1 Delirium
291.0 Delirium tremens
311 Depression
110.9 Dermatophytosis
110.4 Dermatophytosis of foot
250.0 Diabetes mellitus
831.00 Dislocation of shoulder
304 Drug dependence
009.0 Dysentery, unspecified
633 Ectopic pregnancy
692 Eczema, other and dermatitis
492.8 Emphysema
323 Encephalitis, myelitis and encephalomyelitis
617.9 Endometriosis
345 Epilepsy
035 Erysipelas
530.9 Esophagus, functional disorders of
734 Flat foot
787.3 Flatulence
005.0 Food poisoning, staphylococcal
005.9 Food poisoning, unspecified
814.00 Fracture of carpal bone(s)
810.00 Fracture of clavicle
812.20 Fracture of humerus
815.00 Fracture of metacarpal bone(s)
820 Fracture of neck of femur
808 Fracture of pelvis
816 Fracture of phalanges of hand, one or more
813 Fracture of radius and ulna
807 Fracture of rib(s)
733.0 Fracture, spontaneous
825 Fracture of tarsal and metatarsal bones, one or more
800 Fracture of vault of skull
785.4 Gangrene
535 Gastritis & Duodenitis
009.1 Gastroenteritis and colitis
306.4 Gastrointestinal disorders of psychogenic origin
V70 General Examination, Well Patient
241.0 Goiter, non toxic nodular
240.0 Goiter, simple
242.0 Goiter, toxic diffuse
242.3 Goiter, toxic nodular
360.42 Glaucoma
529.0 Glossitis
274 Gout
780.1 Hallucinations
735.0 Hallux valgus and varus
477.9 Hay fever
784 Headache
426.9 Heart block, other
412 Heart disease, asymptomatic ischemic
414.9 Heart disease, chronic ischemic
402.90 Heart disease, hypertensive
429.89 Heart disease, ill-defined
416.8 Heart disease, pulmonary
428.0 Heart failure, congestive
228.01 Hemangioma (of skin)
275.0 Hemochromatosis
282.7 Hemoglobinopathies
641.9 Hemorrhage of pregnancy
455.6 Hemorrhoids
070.1 Hepatitis, infectious
553.3 Hernia, diaphragmatic
550.0 Hernia, inguinal without mention of obstruction
553.1 Hernia, umbilical
054.9 Herpes simplex
053.9 Herpes zoster
786.8 Hiccough
201.9 Hodgkin's disease
373.11 Hordeolum
643.0 Hyperemesis gravidarum
367.0 Hyperopia (farsightedness)
401.1 Hypertension, essential benign
401.0 Hypertension, malignant
458.9 Hypotension
684 Impetigo
487.1 Influenza, unqualified
722.2 Intervertebral disc displacement
830.0 Jaw, dislocation of
386.30 Labyrinthitis
375.00 Lacrimal glands, inflammation of
464.20 Laryngitis and tracheitis, acute
476.0 Laryngitis, chronic
204.1 Leukemia, chronic lymphatic
204.9 Leukemia, lymphatic
205.9 Leukemia, myeloid
205.1 Leukemia, chronic myeloid
528.6 Leukoplakia of oral mucosa
623.5 Leukorrhea
214.9 Lipoma
695.4 Lupus erythematosus
710.1 Lupus erythematosus, systemic
683 Lymphadenitis, acute
289.1 Lymphadenitis, chronic
200.1 Lymphosarcoma (lymphocytic)
579.9 Malabsorption syndrome, unspecified
174.9 Malignant neoplasm of breast
180.9 Malignant neoplasm of cervic uteri
153.9 Malignant neoplasm of large intestine
140.9 Malignant neoplasm of lip
157.9 Malignant neoplasm of pancreas
185.9 Malignant neoplasm of prostate
154.9 Malignant neoplasm of rectum
172.9 Malignant melanoma of skin
151.9 Malignant neoplasm of stomach
193.9 Malignant neoplasm of thyroid gland
V65.2 Malingering
296.80 Manic-depressive psychosis or reaction
676.9 Mastitis and other disorders of lactation
055.9 Measles (rubeola)
386 Menjere's disease
322.9 Meningitis
627.2 Menopausal symptoms
626.9 Menstrual disorders
319 Mental retardation, unspecified
346.9 Migraine
112.1 Moniliasis
075 Mononucleosis, infectious
340 Multiple sclerosis
072.9 Mumps
203.0 Myeloma, multiple
410 Myocardial infarction, acute
367.1 Myopia (nearsightedness)
244.9 Myxedema
470 Nasal septum, deflected
460 Nasopharyngitis, acute (common cold)
472.2 Nasopharyngitis, chronic
787.0 Nausea and vomiting
217 Neoplasm of breast, benign
216.9 Neoplasm of skin, benign
799.2 Nervousness and debility
300.5 Neurasthenia
278.0 Obesity not specified as of endocrine origin
V71.9 Observation, without need for further medical care
650 Obstetrical delivery without mention of complication
715.9 Osteoarthritis
380.10 Otitis externa
382.9 Otitis media without mention of mastoiditis
256.1 Ovarian hypofunction
785.1 Palpitation
332.0 Paralysis agitans
351.0 Paralysis, facial
301.0 Paranoid
297 Paranoid states
427.0 Paroxysmal tachycardia (atrial)
443.9 Peripheral vascular diseases, other
301 Personality disorders
462 Pharyngitis, acute
472.1 Pharyngitis, chronic
451 Phlebitis and thrombophlebitis
451.0 Phlebitis & thrombophlebitis of lower extremities
451.9 Phlebitis & thrombophlebitis of other unspecified sites
300.2 Phobic neurosis
368.13 Photophobia
306 Physical disorders of presumably psychogenic origin
685 Pilonidal cyst
127.4 Pinworm infestation (Enterobiasis)
511.0 Pleurisy
500 Pneumoconiosis
480.9 Pneumonia, viral
486 Pneumonia, unspecified
512.8 Pneumothroax, spontaneous
289.0 Polycythemia, secondary
238.4 Polycythemia vera
710.3 Polymyositis and dermatomyositis
357 Polyneuritis
788.4 Polyuria
V24 Postpartum Care
642.4 Pre-eclampsia and toxemia, unspecified
V23.8 Pregnancy, High Risk (Specify Risk)
V22.0 Pregnancy, Normal First
V22.1 Pregnancy, Normal Other
V03 Prophylactic Immunization Against Bacterial Disease
V04 Prophylactic Immunization Against Viral Disease
V06 Prophylactic Immunization, Multiple Combinations
696.1 Psoriasis and similar disorders
296.90 Psychoses, affective
372.40 Pterygium
415.1 Pulmonary embolism and infarction
287 Purpura and other hemorrhagic conditions
537.81 Pylorospasm
780.6 Pyrexia of unknown origin
782.1 Rash
443.0 Raynaud's syndrome
367.9 Refractive errors
306.1 Respiratory disorder of psychogenic origin
390 Rheumatic fever
391 Rheumatic fever with heart involvement
729.0 Rheumatism, unspecified
V20.2 Routine Infant or Child Health Check
056 Rubella
135 Sarcoidosis
200.0 Sarcoma, reticulum-cell
034.1 Scarlet fever
301.2 Schizoid
295 Schizophrenia
724.3 Sciatica
710.1 Scleroderma
706.2 Sebaceous cyst
706.3 Seborrhea
690 Seborrheic dermatitis
290 Senile dementia & presenile dementia
797 Senility without mention of psychosis
461 Sinusitis, acute
473.9 Sinusitis, chronic
780.50 Sleep disturbance
737.40 Spine, curvature of
378.9 Strabismus
034.0 Streptococal sore throat
692.71 Sunburn (inflammation of the skin & subcutaneous tissues)
780.2 Syncope or collapse
727.00 Synovitis, bursitis and tenosynovitis
091.0 Syphilis, primary
785.0 Tachycardia
525.0 Teeth - absence of (acquired)
521.0 Teeth - Dental caries
524.4 Teeth - malocclusion, unqualified
443.1 Thrombo-angitis obliterans (Buerger's Disease)
287.5 Thrombocytopenia
245.9 Thyroiditis
242 Thyrotoxicosis with or without goiter
463 Tonsillitis, acute
474.1 Tonsils and adenoids, hypertrophy of
131.00 Trichomoniasis unogenitalis
350.1 Trigeminal neuralgia
011.9 Tuberculosis, pulmonary NOS
532 Ulcer of duodenum
533.9 Ulcer, peptic, site unspecified
707.9 Ulcer of skin, chronic
531.9 Ulcer of stomach
465.9 Upper-respiratory infection, acute, unspecified sites
586 Uremia
788.07 Urinary system, pain referable to
708.9 Urticaria
618.1 Uterine prolapse
618.4 Uterovaginal prolapse
621.8 Uterus, atrophy of
616.10 Vaginitis and vulvitis
454 Varicose veins of lower extremities
724.5 Vertebrogenic pain syndrome
079.9 Viral infection, unspecified
783.2 Weight loss

OTHER

_____
_____
_____
_____
_____

PHYSICIAN SERVICE STATEMENT

AUDIT NUMBER

DATE OF SERVICE	FROM (MO.) – (DAY) – (YR.)	TO (MO.) – (DAY) – (YR.)	DATE RECEIVED

PATIENT NUMBER	PHYSICIAN NAME	PHYSICIAN NUMBER
	M.D.	

PATIENT NAME

ENROLLEE NAME

IF PATIENT HAS INSURANCE COVERAGE, PLEASE OBTAIN THE FOLLOWING INFORMATION:
INSURANCE:
☐ BLUE CROSS-BLUE SHIELD ☐ OTHER INS. ☐ MEDICAID ☐ MEDICARE ☐ WORKMAN. COMP.

ICDA-8 CODE	DIAGNOSIS, SYMPTOMS & ILL DEFINED CONDITIONS
	PRIMARY:
	SECONDARY:

REFERRED BY

REFERRED TO

X	SERVICE OR PROCEDURE	CPT4 CODE	USUAL FEE
	OFFICE VISIT - NEW PATIENT		
	BRIEF History, Exam and/or Treatment	90000	
	LIMITED History, Physical Initiation of Treatment	90010	
	INTERMEDIATE History Physical Initiation of Treat.	90015	
	OFFICE VISIT - ESTABLISHED PATIENT		
	MINIMAL Service such as Inj., Immun., Minimal Dressing, etc.	90030	
	BRIEF Exam., Evaluation and/or Treatment	90040	
	LIMITED Exam., Evaluation and/or Treatment	90050	
	INTERMEDIATE Exam., Eval. and/or Treatment	90060	
	HOSPITAL VISIT – INITIAL		
	BRIEF Hist., & Physical Init. of Diagnosis & Treatment	90200	
	INTERMEDIATE Hist., Phys. Initiation of Treatment	90215	
	COMPREHENSIVE History, Phys. Initiation of Treatment	90220	
	HOSPITAL VISIT – FOLLOW-UP		
	BRIEF Exam, Evaluation and/or Treatment	90240	
	LIMITED Exam, Evaluation and/or Treatment	90250	

X	SERVICE OR PROCEDURE	CPT4 CODE	USUAL FEE
	HOME VISITS		
	OTHER TYPE VISITS, CONSULTATIONS, ETC.		
	OTHER MED. SERVICES AND PROCEDURES		

X	SERVICE OR PROCEDURE	CPT4 CODE	USUAL FEE
	LABORATORY		
	RADIOLOGY		

√	PLACE OF SERVICE	√	PLACE OF SERVICE	√	CONDITION DUE TO	DATE
	1–Doctor's Office		5–Extend. Care Fac.		INJURY	
	2–Patient's Home		6–Outpatient Hosp.		INJURY–Covered by Workman Comp.	
	3–Independ. Lab		7–Nursing Home		ILLNESS–Treated Before	
	4–Inpatient Hosp.		8–Outpatient-ER		ILLNESS–First Symptoms	

TOTAL SERVICES ➧

CO-PAYMENTS COLLECTED ➧

PATIENT IS STILL UNDER MY CARE ☐ YES ☐ NO

NO. OF COPAYS

TYPE OF COPAY:
1–MATERNITY
2–PSYCHIATRIC

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the Plan and to furnish information regarding any payments of provided services as the Plan may request for five years from date of service.

PHYSICIAN'S SIGNATURE

IS THE PATIENT TOTALLY DISABLED
FROM / / THRU / /

REMARKS:

CLAIMS COPY B-3

B-4

FORM 4810 REV. 8/79

GENERAL MEDICINE

SCOTT & WHITE

X	DR CODE	NAME OF DOCTOR	X	DR CODE	NAME OF DOCTOR	DATE OF SERVICE
☐	034	S. A. SANCHEZ	☐	271	R.H. JESSE	
☐	031	S. B. LINDSEY	☐	269	D.J. SMITH	
☐	024	A. C. BRODERS, JR.	☐			

REG. #
NAME
ADDRESS
D.O.B.
AGE

IDENTIFICATION IMPRINT TYPE OR WRITE

DESK

REF	CODE	X	DESCRIPTION	REF	CODE	X	DESCRIPTION
	90600.		Consult, Brief (BC)		90020.		H & P, New Patient (H/P)
	90605.		Consult, Standard (C)		90080.		H & P, Return Patient (RH/P)
					90080.02		H & P, Return Spanish Speaking (RSH/P)
	90015.02		Dismissal, Executive Health (ED)		90020.02		H & P, Spanish Speaking, New (SH/P)
	90015.		Dismissal, New Patient (D)				
	90060.01		Dismissal, Return Patient (RD)		90070.		Observation, Extended (EO)
	90060.03		Dismissal, Return Spanish Speaking (RSD)		90050.		Observation, Limited (LO)
	90015.03		Dismissal, Spanish Speaking (SD)		90995.10		Observation, No Charge (NC)
					90060.		Observation, Standard (O)
	90020.01		H & P, Executive (EH/P)				
					90015.10		Preop Exam

☐ IF CHECKED, ALL DIAGNOSES WILL BE USED FOR INSURANCE PURPOSES ONLY (NOT ON THE CONSOLIDATED SUMMARY).
IF NOT CHECKED, ALL DIAGNOSES WILL BE ON THE CONSOLIDATED SUMMARY (THOSE SPECIFIED WITH "S" WILL BE LISTED AS "SUSPECTED" ON THE SUMMARY).

CODE	X	SYMPTOMS
		CARDIO-RESPIRATORY
794.31		Abnormal EKG
793.1		Abnormal Lung X-Ray
427.9		Arrythmia
796.2		Blood Pressure, High
796.3		Blood Pressure, Low
429.3		Cardiomegaly
443.90		Claudication
786.2		Cough
786.0		Dyspnea/Wheezing
782.3		Edema
V17.3		F. H. Ischemic Heart Dis.
412.0		Follow-up MI (Myocardial Infarction)
785.2		Heart Murmur
786.3		Hemoptysis
785.1		Palpitations
786.5		Pain, Chest
786.70		Rales/Rubs
785.0		Tachycardia
		ENDOCRINE / GENERAL
783.0		Anorexia
V18.01		Diabetes Suspect (Family History)
780.7		Fatigue
240.9		Goiter
275.4		Hypercalcemia
V12.20		History gout/hyperuricemia
242.90		Hyperthyroidism on Treatment
244.92		Hypothyroidism on treatment
V18.3		Hyperlipidemia History
241.0		Thyroid Nodule
783.1		Weight Gain
783.2		Weight Loss
		GASTROINTESTINAL
789.0		Abdominal Pain
564.0		Constipation
558.92		Diarrhea
V12.70		Diverticulosis History
787.3		Gas/Bloating
789.1		Hepatomegaly
536.80		Indigestion
789.3		Mass/Lump in Abdomen
787.0		Nausea or Vomiting
569.3		Rectal Bleeding

CODE	X	SYMPTOMS
787.2		Swallowing Difficulty
V12.7		Ulcer History
		GENITOURINARY
611.72		Breast Mass
788.1		Followup, abnormal mammogram
793.80		Dysuria
V18.60		History kidney stone
302.72		Impotence
788.3		Incontinence
611.71		Mastodynia
626.9		Menstrual Disorders
788.4		Nocturia/Frequency
620.8		Ovarian Enlargement
097.1		Serology, Positive
621.2		Uterine Enlargement
623.50		Vaginal discharge
		HEENT
460.		Common Cold
780.4		Dizziness
388.3		Ears, Ringing
379.91		Eye Discomfort
389.8		Hearing, Poor
784.49		Hoarseness
784.2		Lump Head/Neck
784.7		Nosebleed
461.		Sinusitis, Acute
784.94		Sneezing
784.1		Throat Pain
368.		Vision, Poor
		HEMATOLOGY ONCOLOGY
287.9		Bleeding diathesis
459.89		Bruising, ecchymosis
V16.9		Family History ca.
V12.3		History anemia
785.6		Lymphadenopathy
789.2		Splenomegaly
		MISCELLANEOUS
796.90		Abnormal Lab Test
V67.9		Exam, Followup
V01.7		Exposure Viral Disease
780.6		Fever
V70.3		Physical Exam (CAMP, INS, SCHOOL, ETC.)
V67.0		Post-Op Follow-Up

CODE	X	SYMPTOMS
V70.01		Pre-op Evaluation
V70.0		Routine Exam
686.9		Suture Sinus, Infection
		MUSCULOSKELETAL
724.5		Backache
728.2		Muscle Weakness/Wasting
729.1		Myalgia
729.83		Nocturnal cramps
719.4		Pain, Joint
729.5		Pain, Limb
723.1		Pain, Neck
848.9		Sprain, acute
719.5		Stiffness, Joint
719.00		Swelling, Joint
		NEURO-PSYCHIATRY
780.92		Amnesia/failing memory
781.3		Ataxia
293.00		Confusion
780.3		Convulsions
298.90		Dementia
311.		Depression
784.0		Headache
780.52		Insomnia
V61.1		Marital Maladjustment
799.2		Nervousness
782.0		Numbness
344.9		Paralysis
796.1		Reflexes, Poor
438.		Stroke
780.2		Syncope
781.0		Tremor
780.7		Weakness/Fatigue
		SKIN
709.92		Growth, Lesions
782.1		Rash
708.90		Whelps, Hives

CODE	X	DIAGNOSIS
		CARDIOVASCULAR
413.9		Angina Pectoris
441.		Aortic Aneurysm
424.1		Aortic Valve Disease
414.0		Arteriosclerosis
427.3		Atrial Fib. or Flutter
162.9		Ca. Lung
429.3		Cardiac Enlargement
425.		Cardiomyopathy
428.0		Congestive Heart Failure
426.6		Heart Block
401.		Hypertension
458.9		Hypotension
414.00		Ischemic Heart Dis.
394.9		Mitral Valve Disease
V45.0		Pacemaker Check
443.9		Peripheral Vascular Dis.
427.69		Premature Vent. Beats
454.		Varicosities
		ENDOCRINE
250.0		Diabetes Mellitus
276.9		Electrolyte Disorder
251.20		Functional Hypoglycemia
241.9		Goiter, Nodular Non-Toxic
240.0		Goiter, Simple
242.0		Goiter, Toxic Diffuse
790.61		Hyperuricemia
272.9		Lipid Metab., Abnormal
244.9		Myxedema/Hypothyroidism
278.0		Obesity
245.		Thyroiditis
242.		Thyrotoxicosis
		GASTROINTESTINAL
153.		Ca. Colon
154.1		Ca. Rectum
151.		Ca. Stomach
574.2		Cholelithiasis
571.5		Cirrhosis, Unspecified
564.0		Constipation
558.90		Colitis
562.11		Diverticulitis, Colon
562.10		Diverticulosis, Colon
531.		Gastric Ulcer
535.		Gastritis, Duodenitis
558.91		Gastroenteritis,
455.		Hemorrhoids
070.9		Hepatitis, Viral
553.3		Hernia, Diaphragmatic
550.		Hernia, Inguinal
553.20		Hernia, Ventral
553.1		Hernia, Umbilical
564.10		Irritable Bowel
271.3		Lactose intolerance
211.3		Polyp, Colon
569.0		Polyp, Rectal
698.0		Pruritus Ani
564.2		Postgastrectomy (dumping) Syndrome
537.81		Pylorospasm
566.		Rectal/Anal Disease

CODE	X	DIAGNOSIS
		GENITOURINARY
174		Ca. Breast
180		Ca. Cervix
185		Ca. Prostate
179		Ca. Uterus
592.1		Calculus, Kidney or Ureter
616.0		Cervicitis
595.0		Cystitis
618.0		Cystocele
627.9		Menopausal Symptoms
626.9		Menstrual Disorders
622.7		Polyp, Cervical
600.		Prostate Hyperplasia
601.9		Prostatitis
753.1		Renal Cyst
597.80		Urethritis
788.3		Urinary Incontinence
599.0		Urinary Tract Infection
219.90		Uterine Fibromas
616.12		Vaginitis & Vulvitis
		HEENT
366.9		Cataract
372.30		Conjunctivitis
389.9		Deafness
365.9		Glaucoma
477.1		Hay Fever
367.1		Myopia
462.		Pharyngitis, Acute
472.1		Pharyngitis, Chronic
367.4		Presbyopia
473.9		Sinusitis, Chronic
378.91		Strabismus
524.6		T-M Joint Syndrome
780.4		Vertigo
380.4		Wax, Ear
		HEMATOLOGY
280.9		Anemia, Iron Defic.
285.9		Anemia, Unspec.
287.11		Thrombocytopathy
		MISCELLANEOUS
995.3		Allergic Reaction
610.2		Chronic Cystic Dis. Breasts
V65.8		Confidential Diagnosis
700.		Corns & Callouses
524.8		Dento-Facial Anomalies
995.2		Drug Toxicity
214.		Lipoma
079.9		Viral Infection, Unspec.
		MUSCULOSKELETAL
716.9		Arthritis, Unspec.
727.1		Bunions
726.5		Bursitis, Hip
727.31		Bursitis, Shoulder
733.6		Costochondritis
722.52		Disc, Lumbar
722.6		Disc, Unspec.
729.0		Fibrositis
274.9		Gout
719.9		Joint Disease, Other
737.10		Kyphosis

CODE	X	DIAGNOSIS
715.		Osteoarthritis, Generalized
721.0		Osteoarthritis, SPINE CERVICAL (SPONDYLITIS)
715.		Osteoarthritis, Unspec.
721.90		Osteoarthritis, Spine (Unspec. Loca.)
733.0		Osteoporosis
723.4		Radiculitis
714.0		Rheumatoid, Allied Arthritis
846.9		Sacroiliac Sprain
737.3		Scoliosis
724.20		Spinous Process Syndrome
738.4		Spondylolisthesis
848.9		Sprain
726.32		Synovitis, Elbow
		NEUROLOGY
239.6		Brain Tumor
437.9		Cerebrovascular Disorder
780.3		Convulsive Disorder
307.81		Headache, Tension
784.0		Headache, (Unspecified)
354.1		Median Neuropathy
346.		Migraine
781.01		Movement Disorder
294		Organic Brain Syndrome
332.0		Parkinson's Disease
357.9		Polyneuropathy Peripheral
436.		Stroke
780.2		Syncope
435.9		Transient Ischemic Attacks
		PSYCHIATRY
311.		Depression
306.1		Hyperventilation Pschogen.
300.10		Hysterical Neurosis
799.2		Nervousness, Debility(Fatigue)
300.00		Neurosis, Anxiety
300.41		Neurosis, Depressive
300.9		Neurosis, Unspec./Psycho. Disord.
308.3		Transient Situational Disturbance
		RESPIRATORY
493.		Asthma
494.		Bronchiectasis
466.0		Bronchitis, Acute
491.		Bronchitis, Chronic Obst.
496.		COPD (Other Resp. Dis.)
416.9		COR Pulmonale
492.		Emphysema
516.8		Interstitial Pneumonia
486.		Pneumonia
465.9		Upper Respiratory Infection
		SKIN
173.9		Ca. Basal Cell
692.9		Eczema, Dermatitis
216.90		Nevus
110.3		Tinea Cruris
110.5		Tinea Corporis
110.4		Tinea Pedis
110.11		Tinea Ungulum
708		Urticaria
078.12		Verrucae

PLACE LABEL HERE

PLACE LABEL HERE

PROVIDER 1 | PROVIDER 2

M M D D Y Y

AREA

COMMENTS

SERIAL NUMBER 03 0000033

Qty	DESCRIPTION		*No	CODE	FEE
	NEW PATIENT TOS 6				
	ROUTINE OV	9025		2000	
	INTERMEDIATE OV	9026		3000	
	COMP/CONSULT.	9028		5000	
	ESTABLISHED PATIENT TOS 6				
	MINIMAL OV	9024/2		1700	
	ROUTINE	9025/1		2000	
	INTERMEDIATE OV	9026/2		3000	
	COMP/CONSULT.	9028/1		5000	
	SIGMOIDOSCOPY TOS 2				
	DIAGNOSTIC	3400		4000	
	WITH BIOPSY	3402		5500	
	CONSULTS TOS 9				
	COMPREHENSIVE	9153		4000	
	HOSPITAL CARE TOS 6				
	INITIAL VISIT	9076		5000	
	LIMITED VISIT	9075		2000	
	CARE OF NEWBORN	9080		4500	
	MISCELLANEOUS TOS 2				
	CONTUSION				
	FRACTURE				
	SPLINT				
	SPRAIN				
	EMERGENCY TOS 10				
	EMERGENCY RM VISIT	9123		2000	
	FIRST AID TOS 2				
	FIRST AID/NO SUTURE	10001			
	SUPPLIES TOS 15				

DESCRIPTION		*No	CODE	FEE
LABORATORY TOS 8				
CYTOLOGY	8920		900	
ROUTINE URINE	8700		400	
HCT	8368		300	
HGB	8366		300	
DEXTRO	8873		400	
TINE TEST TOS 6	9019/5		400	
VITAL CAPACITY TOS 6	9458		300	
IMMUNIZATIONS TOS 6				
DPT	39019/3		300	
MMR	9019/1		500	
MR	9019/2		500	
MUMPS	9019/3		500	
POLIO	39019/2		300	
RR	9019/4		500	
SMALL POX	9019		300	
T D	39019/4		300	
INJECTIONS	9019			
MINOR SURGERY TOS 2				
HEMATOMA/LARGE	10023			
HEMATOMA/SMALL	10022			
I & D LARGE ABSCESS	10004			
I & D SMALL ABSCESS	10003			
VASECTOMY	4351			
INF. CYST/SINGLE	10008			
INF. CYST/2 LESIONS	10007			
PARONYCHIA	10017			
REMOVE F.B. SIMPLE	10020			
REMOVE F.B. COMP.	10021			
REMOVE IUD	4849/1			
INSERTION OF IUD	4849			

DESCRIPTION		*No	CODE	FEE
LACERATIONS 1 TOS 2				
TR/ARM/LEG/SCLP/NCK	0180			
FACE/EARS/GEN/MOUTH	0180/1			
LACERATIONS 1 - 2½ TOS 2				
TR/ARMS/LEGS	0180/2			
SCLP/NCK/HNDS/FT/GEN	0180/3			
FACE/EAR/EYE/LIP/MOUTH	0180/4			
LACERATIONS 2½ - 5 TOS 2				
TR/ARMS/LEGS	0189			
SCLP/NCK/HNDS/FEET/GEN	0189/1			
FACE/EAR/EYE/LIP/MOUTH	0189/2			
EXCISION/BEN LESION TOS 2				
TRUNK	½" BEN 10070			
ARMS	½" BEN 10070/1			
LEGS	½" BEN 10070/2			
SCALP/NCK	½" BEN 10070/3			
HNDS/FEET	½" BEN 10070/4			
GENITALIA	½" BEN 10070/5			
FACE/EARS	½" BEN 10070/6			
EYE LIDS/LIPS	½" BEN 20070			
NOSE/MUC.MEM.	½" BEN 20070/1			
CORNEA/REMOVE F.B. SUP	5433			
CORNEA/REMOVE F.B. EMB	5435			
BURSA/TENDONITIS/INJ/SM	1573			
BURSA/TENDONITIS/INJ/LG	1573/1			
ASP/BREAST CYST	0450			
SUTURE REMOVAL	0195			
EAR PIERCING	5909/1			
CAUTERIZATION SINGLE	0410			
CAUTERIZATION UP TO 5	0411			
CAUTERIZATION OVER 5	0412			
MEMBER FEE COLLECTED			☐ YES	☐ NO
PLEASE PAY THIS AMOUNT			$	

** Primary Diagnosis/Procedure = 1 Secondary = 2 Tertiary = 3 Other = 4*

*No	DESCRIPTION		*No	DESCRIPTION		*No	DESCRIPTION		*No	DESCRIPTION	
	EXAM MEDICAL	Y019		DIABETES MELLITUS	2500		LABYRINTHITIS	3941		THROMBO PHLEBITIS	4519
	POST PARTUM OBS	Y071		DIZZINESS	7706		LYMPHADENOPATHY	7757		THYROTOXICOSIS	2429
	PRENATAL CARE	Y060		DYSMENORRHEA	6263		MENOPAUSAL SYMPTOMS	6270		TONSILLITIS	4639
	WELL BABY/CHILD CARE	Y001		DYSPEPSIA	7817		MENSTRUAL DISORDER	6269		ULCER/DUODENAL	5320
	ABD/LOWER G I SYMPTOMS	7829		ECZEMA/DERMATITIS	6929		MONO/INFECTIOUS	0759		ULCER/PEPTIC	5330
	ACNE/SEB GLAND	7061		EDEMA	7756		NAUSEA	7811		UNDIAGNOSED DIS.	7939
	ALCOHOLISM	3139		EMPHYSEMA (C.O.P.D.)	4929		NEURITIS/NEURALGIA	3529		UPPER ABDOM. PAIN	780C
	ANEMIA	2809		ENDOMETRIOSIS	6199		OBESITY	2779		UPPER RESP. INFECT.	4659
	ANXIETY	3100		EPILEPSY	3459		ORCHITIS/EPIDIDYMITIS	6049		URINARY TRACT INFECT.	5995
	APPENDICITIS/ACUTE	5400		FATIGUE	7927		OTITIS/EXTERNA	3809		UTERINE FIBROMA	2189
	ARTERIO HEART DIS	4129		FEEDING PROBLEM	7914		OTITIS/MEDIA	3819		VAGINITIS/VULVITIS	6221
	ARTHRITIS	7159		FUO	7922		OVARIAN CYST/BENIGN	2201		VARICOSE VEINS	4589
	ASTHMA/ALL BRONCHITIS	4939		FIBROCYSTIC DIS.BREAST	6109		PERNICIOUS ANEMIA	2810		VASOMOTOR RHINITIS	5079
	ATRIAL FRIBILLATION	4163		GASTRITIS/DUODENITIS	5350		PHARYNGITIS	4629		V.D. UNSPEC.	0999
	BACK PAIN/ACHE	7891		GASTROENTERITIS	0092		PNEUMONIA	4809		VIRAL SYNDROME	0799
	BARTHOLIN'S GLAND/CYST	6221		GOUT	2749		PROSTATITIS	6010		WARTS	0791
	BENIGN NEOPL. SKIN	2169		HEADACHE	7920		PROTEINURIA	Y730		WAX IN EAR	3871
	BRONCHITIS/BRONCHIOLITIS	4990		HEMORRHOIDS	4559		PRURITUS ANI	6980		WEIGHT LOSS	7911
	CELLULITIS/ABCESS	6629		HEPATITIS	5732		RASH	7865		COUNSELING	Y194
	CERVICITIS	6209		HERNIA/INGUINAL	5500		RHEUMATISM	7179		CONJUNCTIVITIS	3900
	CHEST PAIN	7892		HERPES SIMPLEX	0549		RHINITIS	5021		IRRITABLE BOWEL SYND.	5641
	CHOLELITHIASIS	5740		HYPERLIPOPROTEINEMIA	2722		SEBACEOUS CYST	7062		DIVERTICULITIS	5623
	CHOLECYSTITIS	5750		HYPERTENSION/ESSENTIAL	4019		SEROUS OTITIS MEDIA	3811		KNEE DRAINAGE	6824
	CIRRHOSIS OF LIVER	5710		HYPERTHYROIDISM	2420		SKIN INFECTION	6869		TOTAL OBSTETRICAL CARE	6909
	CONGESTIVE HEART FAILURE	4279		HYPOGLYCEMIA	2511		SINUSITIS/ACUTE	5039		DELIVERY DATE	
	CONSTIPATION	5640		HYPOTHYROIDISM	2449		STERILITY	7846			
	CORNS/CALLOSITIES	7009		IMPETIGO	6849		STERILIZATION, VOL.	Y130		DIAGNOSIS FROM CHART IF APPLICABLE	
	CYSTIC KIDNEY DIS.	7531		INFLUENZA/UNSPEC	4709		STREP THROAT	0340			
	CYSTITIS	5959		INGROWN NAIL	7030		SYNOVITIS/BURSITIS	7319			

FAMILY PRACTICE

PLACE LABEL HERE

PROVIDER 1

PROVIDER 2

DEPT. CODE 02

SERIAL NUMBER 0000069

COMMENTS

Qty	DESCRIPTION	*No	CODE	FEE
	NEW PATIENT TOS 6			
	ROUTINE O.V. 9025		2000	
	INTERMEDIATE O.V. 9026		3000	
	COMP. CONSULT. 9028		5000	
	ESTABLISHED PATIENT TOS 6			
	MINIMAL O.V. 9024/1		1500	
	ROUTINE O.V. 9025/1		2000	
	INTERMEDIATE O.V. 9026/2		3000	
	COMP. CONSULT 9028/1		5000	
	HOSPITAL CARE TOS 6			
	INITIAL VISIT 9076		5000	
	LIMITED VISIT 9075		2000	
	PROLONG/DETENT/HR. 9077		6000	
	EXTENDED CONSULT. 9154			
	LUMBAR PUNCTURE TOS 2			
	LUMBAR PUNCTURE 6155		3000	
	EMERGENCY ROOM TOS 10			
	EMERGENCY ROOM 9123		2000	

DESCRIPTION	*No	CODE	FEE
CARDIOGRAMS TOS 8			
EKG/INTER/REPORT 9370		2500	
GRADED EXERCISE TEST 9380		10000	
EKG/EXERCISE 9374		5000	
NURSING HOME TOS 6			
INTERMEDIATE VISIT 9104		3000	
COMPREHENSIVE VISIT 9105			
SIGMOIDOSCOPY TOS 2			
DIAGNOSTIC 3400		4000	
WITH BIOPSY 3402		5500	
LAB TOS 8			
CYTOLOGY 8920		900	
ROUTINE URINE 8700		400	
HCT 8368		300	
HGB 8366		300	
DEXTRO 8873		400	
STOOL GUAIAC 8600		300	
TINE TEST TOS 6 9019/5		400	
VITAL CAPACITY TOS 6 9456		1000	

DESCRIPTION	*No	CODE	FEE
SUPPLIES TOS 15			
CONSULTS TOS 9			
COMPREHENSIVE 9153		4000	
INJECTIONS TOS 6			
FLU SHOT 9019/6			
B-12 9019/7			
IMMUNIZATIONS 9019			
INJECTIONS 9019			
TETANUS 19019/7			
CHEMO RX 9505			
PROCEDURES			
MINOR OFFICE SURGERY			
SUTURE REMOVAL 0195			

MEMBER FEE COLLECTED ☐ YES ☐ NO

PLEASE PAY THIS AMOUNT $

*Primary Diagnosis/Procedure = 1 Secondary = 2 Tertiary = 3 Other = 4

*No	DESCRIPTION	*No	DESCRIPTION	*No	DESCRIPTION	*No	DESCRIPTION
	ABDOMINAL PAIN 7800		CYSTIC DIS/BREAST 6109		INFLUENZA 4709		SCIATICA 3539
	ACUTE PANCREATITIS 5770		DEPRESSION NERVOUS 3106		IRRITABLE COLON 5641		SEIZURES 7703
	AEROPHAGIA 7816		DEPRESSION ACUTE 3092		INTESTINE, LARGE/MAL. 1538		SHINGLES 0538
	ALCOHOLISM 3132		DIABETES MELLITUS 2500		LIVER DIS. UNSPEC. 5739		SINUSITIS 6039
	ALLERGIC RHINITIS 6021		DIARRHEA 7821		MALABSORPTION 2692		STREP THROAT 0340
	ANEMIA IRON DEF. 2809		DIVERTICULI/DIVERTICULO 5621		MENOPAUSE SYMPTOMS 6279		SYNCOPE 7755
	ANEMIA PERNICIOUS 2810		DUODENAL ULCER 5320		MENORRHAGIA 6262		THYROIDITIS 2459
	ANXIETY REACTION 3100		EMPHYSEMA 4929		MENSTRUAL DISORDER 6269		TONSILLITIS 4639
	AORTIC REGURGITATION 3959		ENDOCARDITIS 4219		MIGRAINE 3460		ULCERATIVE COLITIS 5631
	AORTIC STENOSIS 3959		EPIGASTRIC DISTRESS 5369		MITRAL REGURGITATION 3949		ULCERATIVE PROCTITIS 5605
	ARTERIOSCLEROSIS 4409		EPILEPSEY 3459		MITRAL STENOSIS 7451		UNDUE FATIGUE/DEBILITY 7927
	ARTERIOSCL. HEART DIS. 4129		ESOPHAGEAL STRICTURE 5303		M.S. 3409		UPPER RESP. INFECTION 4659
	ARTHRITIS, OSTEO 7130		FUO 7922		MYOCARDIAL INFARCTION 4109		URINARY TRACT INFECTION 5995
	ARTHRITIS 7189		GALLBLADDER DISEASE 5759		NAUSEA 7811		URTICARIA/UNSPEC. 7089
	ASTHMA 4939		GASTRIC ULCER 5310		NEURALGIA/NEURITIS 3529		VAGINAL DISCHARGE 7954
	ATRIAL FIBRILLATION 4163		GASTRITIS/DUODENITIS 5359		OBESITY 2778		VARICOSE VEIN 4589
	BACK PAIN/ACHE 7891		GASTROENTERITIS-INFECT. 0092		OSTEOPOROSIS 7230		VERTIGO/DIZZINESS 7704
	BRONCHITIS, ACUTE 4890		GASTRO ESOPHAGITIS 5301		OTITIS MEDIA 3819		VIRAL SYNDROME 0799
	BRONCHITIS, CHRONIC 4910		G I HEMORRHAGE 7820		PALPITATIONS 7741		WEIGHT LOSS 7911
	BURSITIS, SHOULDER 7311		GOITER, TOXIC 2422		PARKINSONISM 3429		
	CA-METASTATIC 1999		GOUT 2749		PEPTIC ULCER 5330		
	CELLULITIS 6829		HEADACHE (CEPHALALGIA) 7920		PERIPHERAL VASCULAR DIS. 4439		
	CEREBRO VASCULAR DIS. 4379		HEALTHY ADULT 7939		PHARYNGITIS 4629		
	CERVICAL RADICULITIS 7282		HEMORRHOID 4649		PHLEBITIS/TH. PHLEBITIS 4619		
	CHEST PAIN 7892		HEPATITIS 0700		PHYSICAL EXAM Y019		
	CHOLECYSTITIS 5750		HIATAL HERNIA 5516		PLEURISY 5110		
	CIRRHOSIS OF LIVER 5719		HYPERLIPEMIA 2722		PNEUMONIA 4809		
	CONGEST. HEART FAILURE 4279		HYPERTENSION (ESS.) 4019		POISON IVY, OAK, SUMAC 6626		
	CONSTIPATION 5640		HYPERTENSIVE HEART DIS. 4029		PSORIASIS 6961		
	CONVULSIONS 7703		HYPERTHYROIDISM 2429		PULMONARY EMBOLUS 4500		DIAGNOSIS FROM CHART IF APPLICABLE
	COPD 4262		HYPERVENTILATION 7782		RECTAL BLEEDING 7920		
	CROHN'S DISEASE 5630		HYPOTHYROIDISM 2449		REGIONAL ENTERITIS 5630		
	CVA 4390		INFECTIOUS MONO 0759		RHEUMATIC HEART DIS. 3919		

INTERNAL MEDICINE

INTERNAL MEDICINE REPORT OF SERVICES

B-8

PATIENT IDENTIFICATION

IDENTIFICATION #

SUBSCRIBER NAME IF DIFFERENT THAN PATIENT

IMPRINT THIS BLOCK WITH I.D. CARD
OR
PRINT I.D. # AND SUBSCRIBER NAME

PATIENT LAST NAME, FIRST NAME, M.I. | SEX

PATIENT DATE OF BIRTH

IS PATIENT'S CONDITION RELATED TO:
NF ☐ AUTO ACCIDENT WC ☐ EMPLOYMENT

DOES THIS PATIENT HAVE OTHER HEALTH COVERAGE? ☐ YES ☐ NO

NAME OF CARRIER

SERVICE INFORMATION

PLACE OF SERVICE

OF ☐ OFFICE HM ☐ HOME HI ☐ HOSPITAL INPATIENT
AS ☐ ASU NH ☐ NURSING HOME HO ☐ HOSPITAL OUTPATIENT
ER ☐ EMERG. RM. EC ☐ ECF/SNF OT ☐ OTHER _____

PATIENT WAS REFERRED BY
DR

PATIENT SEEN WHILE COVERING FOR
DR

DESCRIBE THE MEDICAL PROBLEMS PRESENTED BY THIS PATIENT

DID THIS VISIT PRIMARILY INVOLVE OR RESULT FROM:

NA ☐ NEW ACUTE ILLNESS FA ☐ FOLLOW-UP ACUTE ILLNESS
NC ☐ NEW CHRONIC ILLNESS FC ☐ FOLLOW-UP CHRONIC ILLNESS
NI ☐ NEW INJURY FI ☐ FOLLOW-UP INJURY
PC ☐ PERIODIC CARE AL ☐ ALCOHOL ABUSE
MA ☐ MATERNITY DG ☐ DRUG ABUSE
MH ☐ MENTAL HEALTH OT ☐ OTHER _____

WERE OUTPATIENT LABORATORY PROCEDURES ORDERED: ☐ YES ☐ NO

PLACE: ☐ RIPA CONTRACTED LAB
☐ OTHER (SPECIFY & EXPLAIN) _____

WERE OUTPATIENT RADIOLOGICAL PROCEDURES ORDERED: ☐ YES ☐ NO

PROVIDER: _____

WERE PRESCRIPTIONS WRITTEN? ☐ YES ☐ NO
INDICATE # ORDERED BEFORE EACH CATEGORY:

A ___ ANTIBIOTICS
B ___ ANTICHOLINERGICS
C ___ ANTIDIABETICS
D ___ ANTIEMETICS
E ___ ANTIHISTAMINES
F ___ ANTITUMOR AGENTS (CHEMOTHERAPY)
G ___ CARDIAC DRUGS (INCLUDING ANTIHYPERTENSIVES)
H ___ CONTRACEPTIVE PREPARATIONS
I ___ DERMATOLOGICALS
J ___ ENDOCRINES STEROIDS
K ___ EXPECTORANTS
L ___ HEMATINICS
M ___ HYPNOTICS
N ___ INJECTIBLES
O ___ SEDATIVES TRANQUILIZERS
P ___ VITAMINS
Q ___ OTHER

OFFICE USE ONLY

DIAGNOSIS USE ICD-9-CM

MAJOR DX RELATED TO VISIT
CODE • DESCRIPTION

OTHER DX
CODE • DESCRIPTION

OTHER DX
CODE • DESCRIPTION

BILLING INFORMATION

DATE OF SERVICE	RVS CODE	DESCRIPTION (IF NOT CIRCLED BELOW) AND COMMENTS/EXPLANATION	AMOUNT BILLED	OFFICE USE ONLY

COMMON RVS CODES (CIRCLE SERVICES RENDERED AND LIST AFTER DATE OF SERVICE ABOVE)

90040	BRIEF OFFICE VISIT	90250	HOSP. VISIT-1st DAY
90050	ROUTINE OFFICE VISIT	90251	HOSP. VISIT-2nd-7th DAY
90140	HOME VISIT	90252	HOSP. VISIT-8th DAY ON
99042	E.R. VISIT AFTER HRS.	93000	EKG
90088	PERIODIC EXAM-ADULT	40240	SIGMOIDOSCOPY WITHOUT BIOPSY
90089	PERIODIC EXAM-GYN	90729	IMMUNIZATION
90090	COLLEGE HIST. & PHYS.	90732	ALLERGY INJECTION
90020	NEW PATIENT WORK-UP	90749	OTHER INJECTION

IF SERVICE OR PROCEDURE IS NOT LISTED HERE, REFER TO HANDBOOK

TOTAL OF SERVICES	
LESS: ____% RISK	
LESS: COPAYMENT	
INITIALLY DUE FROM RIPA	

PROVIDER INFORMATION

NAME OF PROVIDER PROVIDER #

STREET ADDRESS

CITY, STATE, ZIP CODE

CLAIMS SHOULD BE SUBMITTED AS SOON AS POSSIBLE. CLAIMS MUST BE SUBMITTED WITHIN 60 DAYS OF SERVICE TO BE CONSIDERED FOR PAYMENT.

I CERTIFY THE SERVICES LISTED ABOVE WERE RENDERED BY ME OR UNDER MY DIRECT PERSONAL SUPERVISION.

SIGNATURE _____ DATE _____

FOLLOW-UP INFORMATION

PROVIDER'S PLANS FOR PATIENT MANAGEMENT ☐ NONE NECESSARY

FOLLOW-UP PLANS:

☐ NONE
☐ RETURN TO DR. IN ___ DAY/WK/PRN
☐ CALL DR. IN ___ DAY/WK/PRN
☐ CALL PATIENT IN ___ DAY/WK/PRN
☐ • SPECIAL TESTING: _____
☐ • REFERRAL TO OTHER PROVIDER
NAME: _____
SPECIALTY: _____
☐ • HOSPITAL ADMISSION:
HOSPITAL _____
☐ • OTHER: _____

• REFER TO HANDBOOK FOR PRECERTIFICATION GUIDELINES

OBSTETRICS–GYNECOLOGY

B-9

AUDIT NUMBER

DATE RECEIVED	DATE OF SERVICE FROM (MO.) – (DAY) – (YR.)	TO (MO.) – (DAY) – (YR.)	

PATIENT NUMBER	PHYSICIAN NAME	PHYSICIAN NUMBER
	M.D.	

PATIENT NAME

ENROLLEE NAME

IF PATIENT HAS INSURANCE COVERAGE, PLEASE OBTAIN THE FOLLOWING INFORMATION:
INSURANCE:
☐ BLUE CROSS-BLUE SHIELD ☐ OTHER INS. ☐ MEDICAID ☐ MEDICARE ☐ WORKMAN. COMP.

ICDA-8 CODE	DIAGNOSIS, SYMPTOMS & ILL DEFINED CONDITIONS
	PRIMARY:
	SECONDARY:

REFERRED BY

REFERRED TO

X	SERVICE OR PROCEDURE	CPT4 CODE	USUAL FEE
	NEW PATIENT		
	Brief Exam	90000	
	Limited Exam	90010	
	Inter Exam	90015	
	EST. PATIENT		
	Minimal Service	90030	
	Brief Exam	90040	
	Limited Exam	90050	
	Inter Exam	90060	
	Extended Exam	90070	
	HOSPITAL CARE		
	Init Limited Visit	90200	
	Init Inter. Visit	90215	
	Init Compre Visit	90220	
	HOSPITAL FOLLOW-UP		
	Brief Exam	90240	
	Limited Exam	90250	
	Inter Exam	90260	
	Extended Exam	90270	
	HOME VISITS		

X	SERVICE OR PROCEDURE	CPT4 CODE	USUAL FEE
	CONSULTATIONS		
	Limited	90600	
	Intermediate	90605	
	Extensive	90610	
	OTHER PROCEDURES		
	Circumcision (N.B.)	54150	
	Excision (Local) of Lesion, Cervix	57500	
	Cervix Uteri-Biopsy	57520	
	Corpus Uteri-Biopsy	58100	
	D&C, Diagnostic	58120	
	Total Hysterectomy	58150	
	Vaginal Hysterectomy	58260	
	Delivery, Total OB Care, Vaginal Delivery	59400	
	Delivery - Vaginal Only	59410	
	Antepartum - Only	59420	
	Cesarean Section Low Cervical	59500	
	PAP Smear	88150	
	Handling Fee - Lab Test	99000	

X	SERVICE OR PROCEDURE	CPT4 CODE	USUAL FEE
	OTHER PROCEDURES (CONT.)		

√	PLACE OF SERVICE	√	PLACE OF SERVICE	√	CONDITION DUE TO	DATE
	1–Doctor's Office		5–Extend.Care Fac.		INJURY	
	2–Patient's Home		6–Outpatient Hosp.		INJURY–Covered by Workman Comp.	
	3–Independ. Lab		7–Nursing Home		ILLNESS–Treated Before	
	4–Inpatient Hosp.		8–Other Location		ILLNESS–First Symptoms	

TOTAL SERVICES ➧

CO-PAYMENTS COLLECTED ➧

PATIENT IS STILL UNDER MY CARE ☐ YES ☐ NO

NO. OF COPAYS

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the Plan and to furnish information regarding any payments of provided services as the Plan may request for five years from date of service.

PHYSICIAN'S SIGNATURE

IS THE PATIENT TOTALLY DISABLED

FROM / / THRU / /

REMARKS:

TYPE OF COPAY:
1–MATERNITY
2–PSYCHIATRIC

CLAIMS COPY

PATIENT ENCOUNTER FORM

DATE OF SERVICE (MO., DAY, YR.) / /

PROVIDER'S NAME | PROVIDER'S I.D. NO.

PATIENT'S NAME | PATIENT'S I.D. NO. | RELATIONSHIP TO SUBSCRIBER

SUBSCRIBER'S NAME | GROUP NUMBER | SUBSCRIBER'S I.D. NO.

LOCATION: ☐ OFFICE ☐ HOME ☐ HOSPITAL ☐ EXT. CARE FAC.

NATURE OF ENCOUNTER: 1 ☐ ILLNESS FIRST ENCOUNTER 2 ☐ ILLNESS FOLLOW-UP 3 ☐ ANNUAL PHYSICAL 4 ☐ MATERNITY 5 ☐ CONSULTATION

IF CONSULTATION, NAME OF PRIMARY PHYSICIAN | REPORT SENT ☐ YES ☐ NO

INJURY: ☐ ACCIDENT ☐ WORKER'S COMP. | OTHER CARRIER ☐ YES ☐ NO | IF ACCIDENT OR WORKER'S COMP., NAME OF INVOLVED CARRIER | POLICY NO.

SERVICE	CRVS	FEE	SERVICE	CRVS	FEE	SERVICE	CRVS	FEE
New Patient, Brief O.V.	90000		Excis Bartholin's Tumor, Cyst	56740		Cesarean Section Classic	59520	
New Patient, Routine O.V.	90010		Diaphragm Fitting	57170*		Cesarean Sect & Hysterectomy	59560	
New Patient, Intermediate O.V.	90015		Anterior Colporrhaphy	57240		Abortion, Injection W/D&C	59861	
Office Visit, Min. Service	90030		Posterior Colporrhaphy	57250		Abortion Induced By D&C	59862	
Routine Office Visit	90050		Ant-Post Colporrhaphy	57260		Evac Hydatidiform Mole By D&C	59870	
Office Visit, Intermediate	90060		Pelvic Exam, Anesthesia	57410*		T3-T4	84250	
O.V., Extended Re-Exam	90070		Colposcopy	57452*		CBC	85031	
Office Visit (Modality)	97000		Cervix Uteri: Bx, Excis: Les.	57500*		Hematocrit	85014	
Periodic Physical, Adult	90088		Cervix Uteri: Cryocautery	57511*		Hemoglobin	85018	
Home Visit, Brief	90140		Cervix Uteri: Cryoconization	57525		Comb. of 2 (RBC, WBC, HGB)	85034	
Routine Home Visit	90150		Tracheloplasty	57700		WBC	85048	
Initial Hosp. Eval. Limited	90200		Endometrial Biopsy, Suction	58100*		Differential	85007	
Initial Hosp. Evaluation	90215		Endometrial Cytology Sampling	58105*		Urinalysis, Routine	81000	
Initial Hosp. Care, Comp.	90220		D&C. Diag and/or Therapeutic	58120		Pregnancy Test, Gona, Chor	82996	
Subsequent Hosp. Care, Brief	90240		Total Hysterectomy	58150		Pregnancy Test Biocept-G	82999	
Subsequent Hosp. Care, Limited	90250		Vaginal Hysterectomy	58260		RH Type	86082	
Sub. Hosp. Care, Intermed.	90260		Vag. Hyst. W. Vag. Plastic Repair	58285		VDRL	86592	
Sub. Hosp. Care, Extended	90270		IUD Insertion	58300*		Coombs Test Direct	86031	
Critical Care (CCU-ICU)	90290		Insufflation Uterus & Tubes	58320*		Prothrombin Time	85610	
ICU-CCU Follow-Up	90295		Inj. Proc. Hysterosalpingography	58340*		Sedimentation Rate	85651	
Detention, Prolonged (per Hr.)	99040		Uterine Suspension	58400		Throat Culture	87060	
Routine Newborn Care	90285		Salpingectomy	58700		Urine Culture	87086	
Nursing Home Brief	90440		Salpingoplasty Unil.	58741		Gram Stain	87205	
Nursing Home Routine	90452		Wedge Resection Ovary	58920		Glucose	82947	
E.R. Visit, Day	90550		Oophorectomy	58940		Glucose Tolerance	82951	
E.R. Visit, Night	99042		Endoscopy-Laparoscopy:			Pap Smear	88150	
Consultation, Limited	90600		Visual of Pelvic Viscera	58980				
Consultation, Intermediate	90605		Fulguration of Oviducts	58982		Venipuncture Proc. & Interpret.	99008	
Consultation, Extended	90610		Fulg. Ova. Peritoneal Lesions	58984				
Consultation, Comprehensive	90620		Lysis of Adhesions	58985		Other Services:		
Immunization	1		Endoscopy With Biopsy	58986				
Injection	1		Amniocentesis, Abd. Approach	59000*				
I&D Perineal Abscess	56000*		Amnioscopy	59010*				
I&D Bartholin's Abscess	56420*		Fetal Oxytocin Stress Test	59020*				
Marsupialization Barth's Cyst	56440		Fetal Blood Sampling	59030*				
Condylomata, Mult. Simp. Chem.	56500*		Repeat Fetal Blood Sampling	59031*				
Condylomata, Electro-Des	56505*		Fetal Monitoring During Labor	59050*				
Condylomata, Surg. Excis.	56510*		D&C Postpartum Hemorrhage	59160				
Biopsy of Vulva	56600*		Total Obstetrical Care	59400		DIAGNOSIS		
			Vaginal Delivery Only	59440				
			Cesarean Section Low Cervical	59500				
			C. Section & Ant. & Post Care	59501				

1. Indicate Name and Dosage

☐ NO FOLLOW-UP NECESSARY ☐ RETURN VISITS SCHEDULED | DATE (MO., DAY, YR.) / / | REFERRED TO (NAME)

The services rendered were received by me. I authorize TVIPA to release the medical information required in requesting medical service benefits.

PATIENT'S SIGNATURE _____

I certify that the listed services were performed and that the information stated herein is correct.

SIGNATURE OF PROVIDER _____

M M D D Y Y

AREA

AREA

M M D D Y Y

M M D D Y Y

M M D D Y Y

M M D D Y Y

05

0000034

Qty	DESCRIPTION	PROCEDURE	FEE
NEW PATIENT TOS 6			
	ROUTINE O.V. 9020	1500	
	COMPREHENSIVE O.V. 9020	1800	
	COMPREHENSIVE O.V. 9020	2000	
ESTABLISHED PATIENT TOS 6			
	MINIMAL SERVICE 9024/1	800	
	ROUTINE O.V. 9025/1	1000	
	COMPREHEN. O.V. UNDER 3 9026/2	1500	
	COMPREHEN. O.V. OVER 3 9026/3	2000	
	AFTER HOURS VISIT 9026/4	2500	
	SICK VISIT	2000	
PROJECT GOOD HEALTH			
	FULL HEALTH ASSESS. 19020/0	2500	
	FULL ASSESS. VISUAL 19020/1	2500	
	FULL ASSESS. DENTAL 19020/2	2500	
	FULL ASSESS. HEARING 19020/3	2500	
	FULL ASSESS. FOR LEAD 19020/4	2500	
CONSULTS TOS 9			
	COMPREHENSIVE 9152	4000	
HOSPITAL CARE TOS 6			
	INITIAL VISIT 9075	5000	
	LIMITED VISIT 9075	2000	
	PROLONG. DETER./NR. 9077	2000	
	CARE OF NEWBORN 9080	2000	
	ATTEN. AT HIGH RISK DEL. 4070/1	3000	

Qty	DESCRIPTION	PROCEDURE	FEE
LUMBAR PUNCTURE TOS 6			
	LUMBAR PUNCTURE 6100	2000	
SURGERY TOS 2			
	IV CUT DOWN (UNDER 1	2000	2500
	BLADDER CATHER. 4140		
EMERGENCY ROOM TOS 10			
	7 A.M. TO 5 P.M. 9123		
	5 P.M. TO 7 A.M. 9123/1		
LAB TOS 8			
	CYTOLOGY 8020		300
	ROUTINE URINE 8700		400
	HCT 8300		300
	DEXTRO 8073		400
	STOOL, GUAIAC 8900		300
	SICKLE CELL PREP 8442		600
	THROAT CULTURE 8000		
	URINE CULTURE 8000		
	LEAD SCREENING 8200		200
	TINE TEST TOS 8 9010/R		400
	AUDIO/VISUAL TOS 8 9300		500

DESCRIPTION	PROCEDURE	FEE
IMMUNIZATIONS TOS 6		
DPT 90118/2		
MMR 9010/1		
POLIO 90010/3		
TD 90010/4		
ALLERGY SHOT 90010		500
OTHER 9010		
SUPPLIES TOS 10		
MINOR OFFICE SURGERY TOS 2		
EAR LAVAGE 9000/1		
SUTURE REMOVAL 9100		
EAR PIERCING 1420/1		
FIRST AIDING SUTURING 10001		
SUTURING - SIMPLE 9100		
SUTURING - COMPLEX 9100		
I & D 9030		
WART REM. (SURGICAL) 9414		
WART REM. (OTHER)		

RETURN TO CLINIC ON | PLEASE SEE DOCTOR

PAYMENT FEE ON FILED ☐ YES ☐ NO

*Primary Diagnosis/Procedure - 1 Secondary - 2 Tertiary - 3 Other - 4

PLEASE PAY THIS AMOUNT $

*No	DESCRIPTION	*No	DESCRIPTION	*No	DESCRIPTION	*No	DESCRIPTION
	GEN. EXAM/SCHOOL, SUMM.		DIARRHEA		LAW		ASTHMA EMPHYSEM
	PRE-TERM INFANT 7001		SNUFFING		LYMPHADENITIS-UNSPEC		TYMPANITIS
	SINGLE BORN-SINATURE		EPISTAXIS		MALABSORPTION SYNDROME		HYYE
	WELL BABY/CHILD CARE		ECZEMA/DERMATITIS		MENINGITIS		SYNOVITIS, TOXIC
	ABDOMINAL PAIN NONSPEC.		FEEDING PROBLEM		MONONUCLEOSIS		INGUINAL HERNIA
	ACNE		CHD		MUMPS		UTI
	ADJUST REAC. CHILDHOOD		FUNCTIONAL BOWEL SYN.		NEONATAL DIPRYAIN		KIDNEY TRACT DEFECT
	ALLERGY, UNSPECIFIED		FUNCTIONAL MURMUR		NON-GUMARE		VAGINITIS/VULVITIS
	ANEMIA		HAEMATEMESIS		OBESITY		VIRAL ENANTHEM
	ANXIETY		GI BLEEDING		OTITIS EXTERNA		VIRAL ILLNESS
	ARTHRITIS, ANY		GROWTH RETARDATION		OTITIS MEDIA		WARTS
	ASTHMA		HAY FEVER		PARAPLEGIA		THYMUS
	BEHAVIOR PROBLEM		HEADACHE		PHARYNGITIS-ACUTE		
	BOIL/CARBUNCLE		HEARING LOSS		PLEURAL EFFUSION		
	BRONCHITIS		HEMOLYTIC SYN.		PNEUMONIA		
	CELLULITIS, OTHER		HEPATITIS		POISONING		
	CERVICAL ADENITIS		HERPANGINA		POISON IVY		
	CHICKEN POX		HIVES		PYELONEPHRITIS		
	COLIC		HYPERACTIVE BOWEL SYN.		RAD. INJURIES SUNBURNS		
	CONGEN. HEART ANOMALY		HYPERTHYROIDISM		RHEUMATIC FEVER		
	CONJUNCTIVITIS		INFLUENZA		RHEUMATOID ARTHRITIS		
	CONSTIPATION		INGROWN NAIL		SINUSITIS		
	COUGH		INGUINAL HERNIA		STREPTOCOCCAL INFECTION		
	CROUP		INTRAUT. GROWTH RETARD.		SCHOOL PROBLEM		
	DIABETES MELLITUS		JAUNDICE		SEBORRHEIC DERMATITIS		
	DIAPER RASH		LEAD POISONING				
	DIARRHEA		LEUKOCYTOSIS/ANEMIA				

DIAGNOSIS FROM CHART IF APPLICABLE

PEDIATRICS

PLACE LABEL HERE

PLACE LABEL HERE

PROVIDER 1 | PROVIDER 2 | PROVIDER CODE

1 ☐ YES 2 ☐ NO

1 ☐ YES 2 ☐ NO

DATE OF VISIT OR DATE OF ACCIDENT

COMMENTS

DATE CODE 13

SERIAL NUMBER 0000069

DESCRIPTION		*No	CODE	FEE
BACTERIOLOGY T O S 8				
ANTIBIOTIC SENSITIVITY	8887		1100	
CULTURE (SOURCE)	8885		800	
G.C. CULTURE	8880/1		850	
GRAM STAIN (SOURCE)	8880		600	
OCCULT BLOOD (SOURCE)	8800		500	
PINWORM	8807		500	
SEMEN ANAL	8973		1200	
STOOL CULTURE	8885/1		1200	
THROAT CULTURE	8889		750	
URINE CULTURE/CC	8888		1500	
CHEMISTRY - URINALYSIS T O S 8				
ALBUMIN SERUM	8082		750	
AMYLASE	8075		750	
BILIRUB TOT SERUM	8087		750	
BUN	8344		750	
CALCIUM SERUM	8093		750	
CHEMICAL PROFILE	8040		2600	
CHLORIDE PLASMA	8110		700	
CHOLESTEROL SERUM	8112		800	
CO_2 (CONT.PH, CO_2) V	8170		550	
CREATININE SERUM	8125		750	
GLUCOSE BLOOD	8320		700	
GLUCOSE TOL 2°	8322/1		3000	
3°	8322/2		3750	
4°	8322/3		4500	
5°	8322/4		5000	
6°	8322/5		5500	
IRON SERUM	8242		650	
17 KETO STEROIDS	8790			
LDH TOTAL SERUM	8255		800	
LIPASE	8285		1200	
LIPOPRO. PHENOTY.	8268		1800	

DESCRIPTION		*No	CODE	FEE
CHEMISTRY - URINALYSIS T O S 8 (Continued)				
LITHIUM LEVEL	8270		550	
PBI SERUM	8224		600	
PHOSPHATASE ACID	8293		600	
PHOSPHATASE ALK	8295		750	
PHOSPHORUS SERUM	8300		750	
POTASSIUM PLASMA	8301		700	
PROTEIN SERUM	8303		750	
SODIUM PLASMA	8317		700	
THYROID PROFILE	18999		1400	
T_3 UPTAKE	8227		600	
T_4 UPTAKE	8228		600	
FREE T_4	8231			
TRANSAM SGO	8335		800	
TRANSAM SGP	8337		800	
TRIGLYCERIDES	8340		1300	
URIC ACID SERUM	8347		750	
URINALYSIS ROUTINE	8700		500	
VIT B_{12} LEVEL	8352			
HEMATOLOGY T O S 8				
CBC	8362		800	
DIFF	8365		400	
HCT	8368		300	
HGB	8366		250	
LE PREP	8525		800	
PLATELET COUNT	8430		600	
RBC TOTAL COUNT	8363		400	
RETIC COUNT	8440		600	
SED RATE	8441		500	
WBC TOTAL COUNT	8364		300	

DESCRIPTION		*No	CODE	FEE
SEROLOGY T O S 8				
ANTIBODY SCREEN	8483		850	
ANTISTREP TITRE	8473		800	
BLEEDING TIME	8360		400	
BLOOD GROUP ABO	8476		250	
COAG. TIME (CAP)	8403		500	
COLD AGGLUTININS	8486		650	
MONO SCREENING	8510		750	
PROTHROMBIN TIME	8434		700	
RH TYPE	8480		600	
RUBELLA HI SINGLE	8527		700	
VDRL	8534/1		500	
MISCELLANEOUS T O S 8				
ANA	8472			
GLUCOLA T O S 15	8699/2		150	
HANDLING FEE	8000		1000	
PREGNANCY TEST	8202		900	
PREMARITAL	8534		550	
PV COUNT	8948		400	
RA FACTOR	8520		800	

*Primary Diagnosis/Procedure = 1 Secondary = 2 Tertiary = 3 Other = 4

PLEASE PAY THIS AMOUNT $

OTHER TESTS (IF INDEPENDENT LABORATORY, ENTER INFORMATION HERE)

VENDOR NUMBER	VENDOR NAME	DESCRIPTION	PROCEDURE CODE	CHARGES	DIAGNOSIS CODE
				$	
				$	

	CODE	FEE
SPECIAL INSTRUCTIONS		

DIAGNOSIS FROM CHART IF APPLICABLE

LABORATORY

REFERRAL AUTHORIZATION

PATIENT		REFERRING PHYSICIAN/GROUP	
patient number		physician	Health Plan Coord.
patient name	phone	group name	phone
address		address	
subscriber (if patient is a minor)		physician signature	

CONSULTING PHYSICIAN

physician	appointment date and time
address	phone
reason for referral	

TO THE MEMBER

Treatment for other conditions is not covered unless prior authorization is received. I have read the above statement and understand that I must pay for any care received beyond that which is authorized.

patient signature _____ relationship (if patient is a minor) _____

date _____ witness _____

TO THE CONSULTANT

This notice authorizes the following care:

☐ Evaluation Only—single visit

☐ Evaluation and treatment

☐ Other (specify) _____

If consultation is all that is required, please return your report, this form and bill to the referring physician group. If our patient requires further care by you, inpatient or outpatient not already authorized, please contact the referring physician or health plan coordinator to request authorization. We prefer a written request, but use the phone if it is an emergency. Please send a copy of this form with each report.

Consultant Comments: _____

COPY DISTRIBUTION: WHITE–Consulting Physician, YELLOW–Patient, PINK–Chart, GOLD–Office

AUTH. NO IF NEEDED

REFERRAL AUTHORIZATION

CONSULTANT

DATE

REFERRING PHYSICIAN

PATIENT NAME

PATIENT NUMBER

PROBLEM: _____

DRUG ALLERGIES: _____

CURRENT MEDS: _____

SERVICES REQUESTED

- ☐ EVALUATION AND REPORT (CIRCLE NUMBER OF VISITS AUTHORIZED IF MORE THAN ONE)
  1 2 3 4 5
- ☐ SPECIAL PROCEDURES (LIST BELOW)
- ☐ THERAPY (DESCRIBE BELOW)

REMARKS _____

DOCUMENTS ATTACHED (A) OR UNDER SEPARATE COVER (S)

NARRATIVE REPORTS	( )
LAB REPORTS	( )
XRAY REPORTS	( )
XRAY FILMS	( )
OTHER	( )

SIGNATURE OF REFERRING PHYSICIAN

REFERRING PHYSICIAN: Make certain that (1) you are this patient's primary physician, (2) the consultant is a HealthPlus Provider (call if necessary) and (3) all appropriate medical records are provided to the consultant.

OUT OF PLAN REFERRAL REQUIRES HEALTHPLUS APPROVAL AND AUTHORIZATION NUMBER.

HEALTHPLUS CONSULTANT: Make certain (1) that you have this form, (2) you are a currently contracted HealthPlus Provider. This white copy should accompany your claim to HealthPlus. The green copy should accompany your report to the referring physician.

IF SERVICES BEYOND THOSE AUTHORIZED, OR IF ADDITIONAL REFERRALS ARE NEEDED, CONSULT REFERRING PHYSICIAN.

NON PLAN CONSULTANT: Make certain that an authorization number appears at upper left. Only those services indicated are authorized for payment. Please send the green copy with your report to the referring physician and the white copy with your bill to HealthPlus.

PATIENT: This form authorizes certain care which otherwise would not be covered.

AUTHORIZATION FOR HOSPITALIZATION

DATE _____

PATIENT BIRTH DATE	MO	DAY	YR

PATIENT INFORMATION

NAME OF PATIENT			EMPLOYER GROUP NO.
ADDRESS	CITY	STATE	ZIP
PATIENT'S RELATIONSHIP SUBSCRIBER ☐ DEPENDENT ☐			

ADMISSION INFORMATION

NAME OF HOSPITAL TO BE USED	MEDICAL GROUP
ADMITTING DIAGNOSIS (or reason)	

THIS PATIENT IS AUTHORIZED FOR ADMISSION ON	MO	DAY	YR

ESTIMATED LENGTH OF STAY	NUMBER OF DAYS

THIS ADMISSION IS AUTHORIZED BY _____ , M.D.
ATTENDING PHYSICIAN SIGNATURE

THIS ADMISSION IS APPROVED BY _____ , M.D.
DESIGNATED PHYSICIAN SIGNATURE

COMMENTS PERTINENT TO THIS ADMISSION

INSTRUCTIONS FOR USING THIS FORM

1. This form must be completed for all admissions as a condition of coverage, including admissions requested by referring physicians.
2. This form must be completed in advance of all elective admissions.
3. White and canary copies to hospital.
4. Pink copy to patient's medical group chart.
5. Goldenrod copy kept by the I.P.A.

MEMBER NAME

BIRTH DATE
I. D. NO.

PLAN NO.
EFFECTIVE DATE

PRIMARY PHYSICIAN

ADMISSION AUTHORIZATION

Name of Hospital to Which Patient Was Referred:

Type of Room: Date to be Admitted:

AUTHORIZED BY:
*Primary Care Physician/HEALTHWISE

ADMITTING PHYSICIAN:

REMARKS: Diagnosis: (Primary)

(Secondary)

Pert. HX:

Plan of treatment:

Surg. Procedure: Date Scheduled:

Discharge Planning ☐ Yes ☐ Unsure

TO BE COMPLETED BY RECEIVING PROVIDER

Remarks:

THIS AUTHORIZATION ENTITLES HEALTHWISE MEMBER TO FULLY COVERED HOSPITAL BENEFITS.

Original—Healthwise **Blue—Hospital** **Yellow—Primary Care Physician**

HOSPITAL ADMISSION CERTIFICATION

PHYSICIAN'S NAME: _____

PROVIDER NUMBER: _____

DATE OF REQUEST: _____

HOSPITAL: _____

ADMITTING DATE: _____

PATIENT'S NAME: _____

PATIENT I.D. NO.: _____

SUBSCRIBER NO.: _____

Adm. Diag. CPT4 Codes	Surgical CPT4 Codes	Type of Admit:	Admit Service:	Physicians:
1.	1.	Elec. ○ Urg. ○ Emerg. ○	Med. ○ Ortho. ○ Surg. ○ Ped. ○ OB-GYN ○ Psy. ○	Primary Care Physician:
2.	2.	Sched. Surg. Date: M M D D Y Y		
3.	3.			Surgeon:
4.	4.			

Admitting Diagnosis:

Surgical Procedures:

Approval Date: _____

Certified LOS: _____

Extension Request

Date Deadline _____

Request Date _____

Requesting Physician Signature _____

Medical Director Signature _____

REQUEST FOR EXTENSION OF CERTIFICATION

Name of Patient	(Last)	(First)	(Middle Initial)

Patient HMO Identification No.	Hospital Identification No.	Room No.	Hospital Adm. Date	

FOR PHYSICIAN

Initial Number of days Certified	Length of Extension Requested Beyond Initial Certification (Number of Days)

DIAGNOSIS AND BRIEF CLINICAL SUMMARY

Reason for requested extension

_____ M.D. _____
Physician Date

FOR MEDICAL DIRECTOR

	Number of Additional Days Certified	Date Approved	Expired
APPROVED			
DISAPPROVED			

Signature _____ M.D. Date _____

CONTROL COPY

BLUE CROSS IDENTIFICATION NUMBER

SERIAL NO. 0001607

DATE OF REFERRAL

STATUS CODE

REFERRAL FORM

CONSULTANT INFORMATION

NAME OF CONSULTANT

TELEPHONE NUMBER

STREET ADDRESS

CITY STATE ZIP CODE

PROVIDER CODE

SERV. CODE

APPOINTMENT INFORMATION

DAY

TIME ☐ AM ☐ PM

DATE

REASON FOR REFERRAL

☐ DIAGNOSIS AND RECOMMENDATIONS ☐ PROCEED WITH DIAGNOSTIC STUDIES ☐ TREAT IF NECESSARY

ENCLOSURES ☐ YES ☐ NO

PROVIDER CODE

APPROVAL

NUMBER OF VISITS ☐ 1 ☐ 2 ☐ 3

THANK YOU –

OUTPATIENT SERVICES

NO. OF VISITS | NO. OF SERVICES | DATES OF SERVICES FROM | TO

PROCEDURE	PROCEDURE CODE	DIAGNOSIS	DIAGNOSIS CODE	UNITS	CHARGES	PAID
PROCEDURE	PROCEDURE CODE	DIAGNOSIS	DIAGNOSIS CODE	UNITS	CHARGES	PAID
PROCEDURE	PROCEDURE CODE	DIAGNOSIS	DIAGNOSIS CODE	UNITS	CHARGES	PAID
PROCEDURE	PROCEDURE CODE	DIAGNOSIS	DIAGNOSIS CODE	UNITS	CHARGES	PAID
PROCEDURE	PROCEDURE CODE	DIAGNOSIS	DIAGNOSIS CODE	UNITS	CHARGES	PAID

OUTPATIENT CROSS REFERENCE SERIAL NUMBER

TOTAL OUTPATIENT CHARGES & TOTAL AMOUNT PAID

TOTAL CHARGES | TOTAL AMOUNT PAID

INPATIENT SERVICES

NO. OF VISITS | NO. OF SERVICES | DATES OF SERVICES FROM | TO

PROCEDURE	PROCEDURE CODE	DIAGNOSIS	DIAGNOSIS CODE	UNITS	CHARGES	PAID
PROCEDURE	PROCEDURE CODE	DIAGNOSIS	DIAGNOSIS CODE	UNITS	CHARGES	PAID
PROCEDURE	PROCEDURE CODE	DIAGNOSIS	DIAGNOSIS CODE	UNITS	CHARGES	PAID
PROCEDURE	PROCEDURE CODE	DIAGNOSIS	DIAGNOSIS CODE	UNITS	CHARGES	PAID
PROCEDURE	PROCEDURE CODE	DIAGNOSIS	DIAGNOSIS CODE	UNITS	CHARGES	PAID

INPATIENT CROSS REFERENCE SERIAL NUMBER

TOTAL INPATIENT CHARGES & TOTAL AMOUNT PAID

TOTAL CHARGES | TOTAL AMOUNT PAID

FOR HEALTHWAY USE ONLY

COMMENTS

GRAND TOTALS

TOTAL CHARGES

TOTAL AMOUNT PAID

CHECK NO.

APPROVAL BY REF. PROV. ☐ YES ☐ NO

SIGNATURE

DATE SIGNED

DATE PAID

CONFIDENTIAL

SUBMIT CONSULTANT'S REPORT WITH THIS FORM

☆ U.S. Government Printing Office : 1985 - 491-350/47704

HMO

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Public Health Service
Office of the Assistant Secretary for Health
Office of Health Maintenance Organizations
Division of Development
Rockville, Maryland 20857

POSTAGE AND FEES PAID
U.S. DEPARTMENT OF H.H.S.
HHS 396
Fourth Class
Printed Matter

U.S. MAIL

DHHS Publication No. (PHS) 81-50165